

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04389

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN M. ROSE   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 20 84 |   |  | 2b. HOUR<br>M<br>84   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 26 45   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>38 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                                     |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4502 Clareway Road |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Aubrey  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Henderson  |  | 13e. STREET ADDRESS<br>4502 Clareway Rd. 21213  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>212-52-8433   |  | 17. INFORMANT ADDRESS<br>Darryl Rose 4502 Clareway Road   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY APNEST</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>WIDELY METASTATIC LARGE CELL</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>UNDIFFERENTIATED LUNG CARCINOMA</u> |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> 19 <u>84</u> to <u>2/20</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Victor Vogel</u>   |  | DEGREE<br><u>MD</u>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>2/20/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>VICTOR VOGEL, MD</u>  |  | 22e. ADDRESS<br><u>JOHNS HOPKINS ONCOLOGY CENTER</u>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(a) <u>BURIAL</u>  |  | 23b. DATE<br><u>2/25/84</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus Mem. Pk.</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Arbutus, Md</u>                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Wm C March F/H Inc. 1101 E North Avenue</u>  |  |   |  | 25a. DATE REG'D. BY REG'D. CLERK<br><u>FEB 21 1984</u>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |   |                                    |                                |                                   | REG. NO.   |  |
|---|--|--|--|--|---|---|------------------------------------|--------------------------------|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 2a. DATE OF DEATH   |   |                                    |                                |                                   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |   |                                    |                                |                                   | 2b. HOUR   |  |
| Marguerite L. Rose  |  |  |  |  | February 10 1984  |   |                                    |                                |                                   | 3 PM   |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                                    | 7. UNDER 1 YEAR                |                                   | 8. UNDER 24 HRS  |  |
| Female  |  | White  |  | Nov. 21 1896   |   | 87  |                                    | MONTHS DAYS                    |                                   | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                    |                                |                                   |  |  |
| N.Y.  |  | U.S.A.   |  |  |   | Baltimore City MD.  |                                    |                                |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                    |                                | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Baltimore   |  | Meridian Nursing Home-Long Green   |  |  |   | Green Homemaker   |                                    |                                |                                   |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |                                    | 13e. STREET ADDRESS / ZIP CODE |                                   |  |  |
| Md.   |  | -  |  | Baltimore  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                    | 2611 Kentucky Ave. 21213       |                                   |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |   |                                    |                                |                                   |  |  |
| Ford  |  |  |  |  | Latham  |   |                                    |                                |                                   | Corra Sydney   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS              |                                |                                   |  |  |
| no  |  |  |  |  | 213-48-4411   |   | Carol English (dghtr) same address |                                |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |   |                                    |                                |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |   |   |                                    |                                |                                   |  |  |
| IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease.</i>  |  |  |  |  |   |   |                                    |                                |                                   | 2 yr.  |  |
| 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized A.S.</i>   |  |  |  |  |   |   |                                    |                                |                                   | 10 yr.   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |   |   |                                    |                                |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |   |   |                                    |                                |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Cachexia 2nd to malnutrition -</i>  |  |  |  |  |   |   |                                    |                                |                                   |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |                                    |                                |                                   | 20a. AUTOPSY?  |  |
|   |  |  |  |  |   |   |                                    |                                |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |   |                                    |                                |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |
|   |  |  |  |  | P.M. 19   |   |                                    |                                |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    |                                |                                   | 21f. LOCATION  |  |
|   |  |  |  |  |   |   |                                    |                                |                                   | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |                                    |                                |                                   |  |  |
| 22b. SIGNATURE  |  |  |  |  |   |   |                                    |                                |                                   | 22c. DATE SIGNED   |  |
| <i>Norman R. Freeman MD</i>   |  |  |  |  |   |   |                                    |                                |                                   | 2/13/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |   |   |                                    |                                |                                   | 22e. ADDRESS   |  |
| Dr. Norman Freeman  |  |  |  |  |   |   |                                    |                                |                                   | 11 W. 29th St.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |                                |                                   | 23d. LOCATION  |  |
| Cremation   |  |  |  |  | 2/13/84   |   | Greenmount                         |                                |                                   | Baltimore CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL HOME  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |   |                                    |                                |                                   | 25b. REGISTRAR'S SIGNATURE   |  |
| Schimnek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213  |  |  |  |  | FEB 14 1984   |   |                                    |                                |                                   | <i>Julia Davidson-Randall</i>  |  |

LIBRARY

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1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

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The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 772-1000 death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04391

REG. NO.

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR  |  |  | 2b. HOUR  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST  |  |  | 2. DATE OF DEATH  |  |  | 2b. HOUR  |  |  |
| MARJORIE LOW Rosenheim   |  |  |  |  |  | 2. 2 22 84  |  |  | 12 PM   |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  |
| FEMALE   |  |  | WHITE  |  |  | MONTH DAY YEAR  |  |  | 64 YRS.   |  |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| NEW YORK   |  |  | U.S.A.   |  |  | 10. 16 1919   |  |  | BALTIMORE CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| BALTIMORE  |  |  | SINAI HOSPITAL   |  |  | HOMEMAKER   |  |  |   |  |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |  |  |
| Maryland   |  |  | Baltimore  |  |  | PIKEVILLE   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |
| JULIUS E. LOW  |  |  | ELSIE SHAPIRO  |  |  | NO  |  |  | 216.07.0695   |  |  |
| 17. INFORMANT  |  |  | ADDRESS  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Breast cancer to Pleura and lung.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |
| LOUIS G. ROSENHEIM   |  |  | SAME AS 13c.   |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION   |  |  |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/13/84</u> to <u>2/22/84</u> , that (I) (we) lost the deceased alive on <u>2/23/84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE <u>Giora A. Praff</u>   |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS   |  |  |   |  |  |   |  |  |
| GIORA A. PRAFF   |  |  | 7903 Brookford Circle Pikesville, MD 21208   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION   |  |  |
| CREMATION  |  |  | 2/23/1984  |  |  | GREEN MOUNT CREMATORY   |  |  | BALTIMORE, MARYLAND   |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |   |  |  |
| WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222   |  |  | FEB 24 1984  |  |  | Julia Davidson-Randall  |  |  |   |  |  |

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|  |  |   |   |   |  |  |   |  |
|--|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES C. ROYAL</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 18, 1984</b> |   | 2b. HOUR<br><b>2:32 P.M.</b>   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/18/1916</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                          |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TENNESSEE</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.          |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAINTENANCE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LABORER</b>                        |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>2002 E. PRATT ST.</b>                            |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD ROYAL</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BESSIE MORGAN</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>8 MEADOW GREEN DR.<br/>BOB MOWERY RINGGOLD GA. 30736</b>   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CONGESTIVE HEART FAILURE</b>                                      |  |   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>PERIPHERAL VASCULAR DISEASE</b>   |  |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>FEBRUARY 17, 1984</b> , to <b>FEBRUARY 18, 1984</b> , that (1) (we) lost<br>saw the deceased alive on <b>FEBRUARY 18, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>L. K. Peredo</b>  |  |   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>FEB 18, 1984</b>                                    |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. K. PEREDO, MD.</b>  |  |   |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION, 100 N.<br/>BROADWAY, BALTIMORE, MARYLAND 21231</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2/22/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHATTANOOGA CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CHATTANOOGA TENNESSEE</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>CHATTANOOGA FUNERAL HOME</b>  |  |   |   | 1724 MC CALLIE AVE.<br><b>CHATTANOOGA TENN.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 28 1984</b>                        |   |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendell</b>  |  |  |   |  |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04393

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |  |   |  |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rosa</b> <b>Ruck</b>  |  |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>2</b> YEAR <b>84</b>            |   |  | 2b. HOUR <b>10:50A</b> M   |  |   |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH MONTH <b>1</b> DAY <b>17</b> YEAR <b>00</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>1</b> DAYS <b>1</b> HOURS <b>1</b> MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD                                |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |  |
| 13a. STATE <b>MD.</b>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN <b>BALTO.</b><br><b>CITY</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>APT. 1117 #21215</b><br><b>2500 W. BELVEDERE AVE</b>   |  |
| 14. FATHER'S NAME FIRST <b>SAMUEL</b> MIDDLE LAST <b>GORDON</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>EMMA</b> MIDDLE LAST <b>MOSSOVITZ</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>218 32 1044</b>  |   | 17. INFORMANT <b>MRS. SELMA ADONER</b>  |  | 7211 PARK HTS. AVE. APT. 105   |  | #21208  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC &amp; RESPIRATORY ARREST</b><br><b>1910</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL BRAIN NEOPLASM</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b><br><b>2 MONTHS</b> |  |  |   |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>antibiotic heart disease &amp; chronic heart failure</b>   |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>JAN 18</b> , 19 <b>84</b> , to <b>FEB 2</b> , 19 <b>84</b> , that (1) (we) lost saw the deceased alive on <b>FEB 2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Manuel Levin</b> MD  |  |  |   | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>2/2/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MANUEL LEVIN. M.D.</b>  |  |  |   | 22e. ADDRESS <b>6121 PARK HTS AVE BALTO MD 21215</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>FEB. 3, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>  |  | 23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE                     |  |   |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>6010 Reisterstown Rd. Balto., MD 21215   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Joan J. Connel</b>  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director within 24 hours after death. Pages 3 and 4 should be filed with the funeral director within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director within 24 hours after death. Pages 3 and 4 should be filed with the funeral director within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04394

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mildred Ruth                                     |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 17 84 |  |  | 2b. HOUR<br>10:20 PM  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 12 02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Saleslady                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Campbell Millinery          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |  |  |   |  |  |  |
| 13a. STATE<br>Md  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3305 Devonshire Drive 21215               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Judson Crowell                                |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Forsythe  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no              |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-03-0869   |  | 17. INFORMANT Mr. John Ruth<br>ADDRESS<br>3305 Devanshire Dr. Baltimore, Md. 21215              |  |  |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

0389 IMMEDIATE CAUSE (a) Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/7, 1984, to 2/7, 1984, that (I) (we) lost<br>saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>J. Zwermer MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/7/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Zwermer MD  |  |  |  | 22e. ADDRESS<br>Sinai Hospital   |  |   |  |

|  |  |                     |  |  |  |   |  |
|--|--|---------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>2-9-84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory |  | 23d. LOCATION<br>Catonsville Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road Randallstown, Maryland 21133 |  |                     |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 10 1984             |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MADE IN U.S.A.



WINTER  
100% COTTON  
FIBER

MADE IN U.S.A.

MADE IN U.S.A.



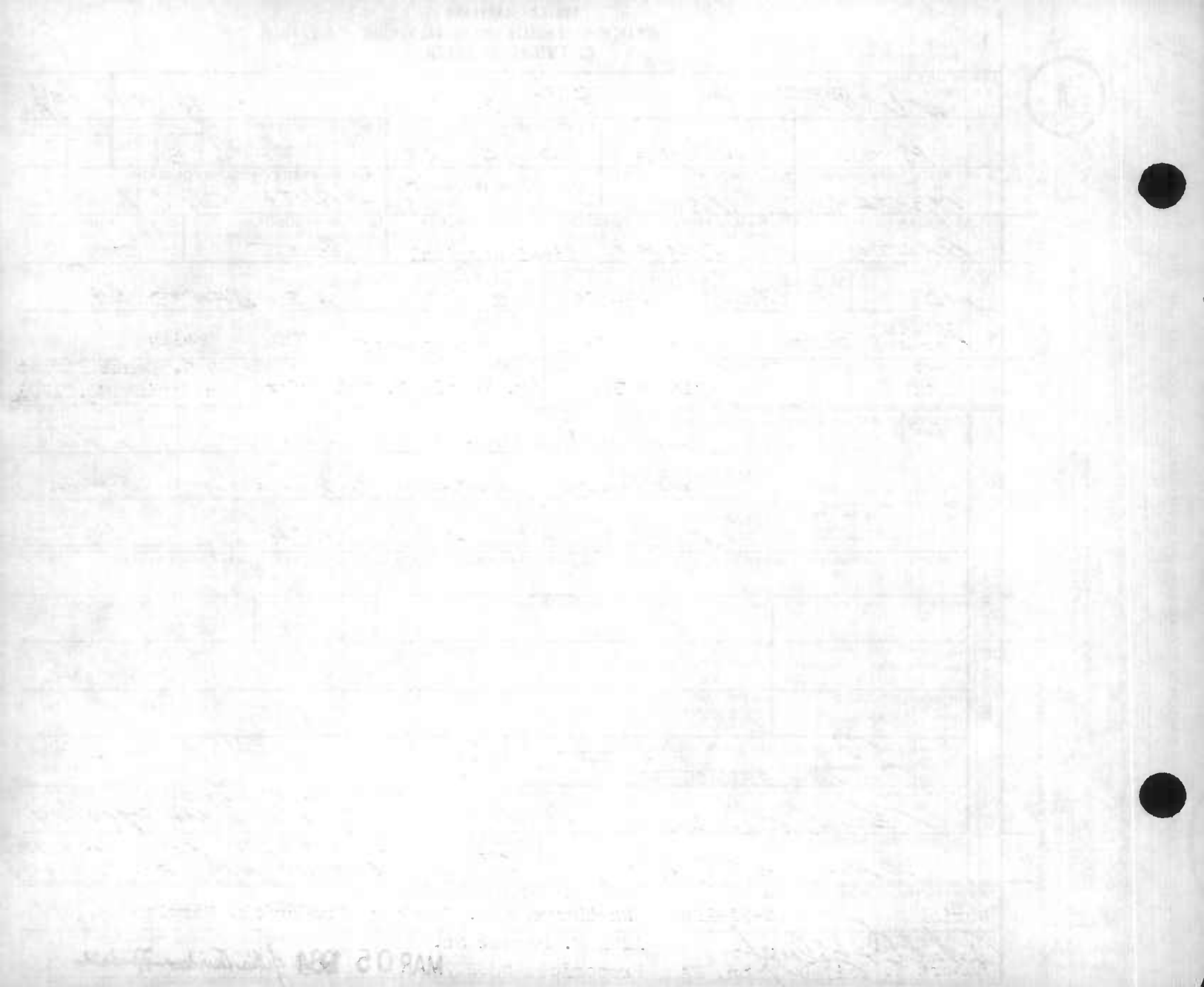
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |  |  | 04395   |  |
|---|--|--|---|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |   |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JUSTIN LEE RUTHERFORD</b>  |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2 19 84</b>   |   |  | 2b. HOUR<br><b>6:04 AM</b>                         |  |   |  |
| 3. SEX<br><b>M Male</b>   |  | 4. RACE<br><b>W White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 19 83</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>-0- YRS <b>5</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Sinai Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>FREDERICK</b>  |   | 13c. CITY OR TOWN<br><b>FREDERICK</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>40 S. BENTZ ST 21701</b> |  |   |  |
| 14. FATHER'S NAME<br><b>RONALD Joseph RUTHERFORD</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br><b>VICKIE Sue Welty</b>  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-04-3213</b>   |   | 17. INFORMANT ADDRESS<br><b>Mr. Ronald J. Rutherford Frederick, Md. 21701</b>   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>7670</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SEVERE BRAIN DAMAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PERINATAL ASPHYXIA</b> |  |  |   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hr</b><br><b>5 min</b><br><b>5 min</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |  |   |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>14/5 19 83</b> to <b>2/19 19 84</b> , that (I) (we) lost <b>2/19 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Paul Borgan</b>  |  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/19/84</b>   |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL BORGAN</b>   |  |  | 22e. ADDRESS<br><b>MT. WASHINGTON PEDIATRIC HOSP<br/>1208 W. ROGERS AVE BALTO 21209</b> |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>2-21-1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resthaven Mem. Gardens</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Maryland</b>             |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Dailey &amp; Son, PA</b>   |  |  | 1201 N. Market St<br>Frederick, Md. 217   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 05 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                          |  |  |   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

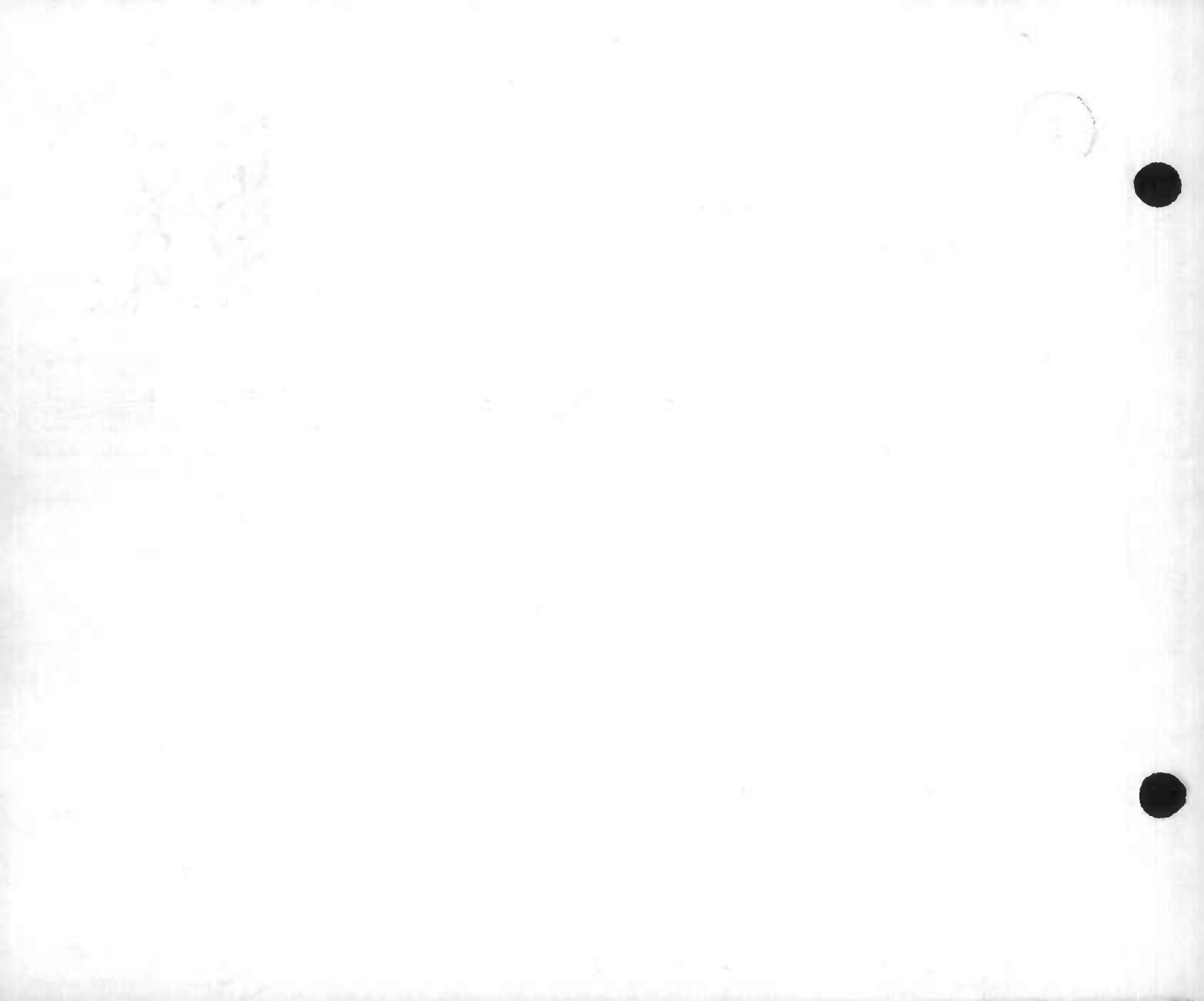
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04396

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | HOURS MIN.  |  |
| FIRST MILDRED R   |  | 2-16-84  |  | 8:55 PM   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |
| FEMALE  |  | WHITE  |  | MONTH DAY YEAR  |  |
|   |  |  |  | 12-18-02  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. AGE (IN YEARS LAST BIRTHDAY)   |  |
| Maryland  |  | U.S.A.   |  | 81 YRS.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Baltimore   |  | GOOD SAMARITAN HOSPITAL  |  | BALTIMORE CITY MD.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| Housewife   |  |  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| Maryland  |  |  |  | Baltimore   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13d. INSIDE CITY LIMITS?  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |
| Edward Rudiger  |  | Unknown  |  | 21214   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |
| No  |  | 216070654  |  | Edward C Rudiger 13210 Springdale Estate                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) - Pulmonary embolism  |  |  |  |   |  |
| 4151  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |
| (b)   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |
| (c)   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |
|   |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |
| WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |
| AT WORK AT WORK   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-6-1984, to 2-16-1984, that (I) (we) lost saw the deceased alive on 2-16-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| S. Khan   |  |  |  | 2-16-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |
| SHAKERA KHAN  |  | GOOD SAMARITAN HOSP.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 2/20/84  |  | Parkwood  |  |
| 24. FUNERAL DIRECTOR  |  | 23d. LOCATION  |  | 23e. DATE REC'D. BY REGISTRAR   |  |
| NAME Leonard J Ruck Inc. Baltimore, Maryland  |  | CITY OR TOWN COUNTY STATE  |  | BALTIMORE, MARYLAND   |  |
|   |  |  |  | FEB 21 1984   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04397

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEWIS C. SADLER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 1, 1984</b>                                      |  | 2b. HOUR<br><b>10:29 PM</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-24-92</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Salesman</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3204 Batavia Ave. 21214</b>                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Sadler</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown Unknown</b>                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI 578-14-0862</b>   | 17. INFORMANT ADDRESS<br><b>Beatrice A. Maggio, 47 Carling Cir. 21227</b>                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4860 IMMEDIATE CAUSE (a) PNEUMONIA</b>   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>CONGESTIVE HEART FAILURE</b>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>84</b> , to <b>2/1</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/1</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>John Hart M.D.</b>  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>2/1/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN HART</b>  |   | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2-4-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., Balto., Md.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04398

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |  |   |  |  |
|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Sample</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>1</b> YEAR <b>84</b>   |  | 2b. HOUR<br><b>4:16</b> <sup>P</sup> <sub>M</sub>                                |
| 3. SEX<br><b>Fem</b>  | 4. RACE<br><b>Col</b>  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>23</b> YEAR <b>98</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>                                     |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Home Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Balto</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>Summers</b> LAST <b>Summers</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Emma</b> MIDDLE <b>Nelson</b> LAST <b>Nelson</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-4696</b>  |  | 17. INFORMANT<br><b>Margaret Nicholson</b> ADDRESS <b>3615 Cottage Ave 21216</b> |

|   |  |   |
|---|--|---|
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4/100</b> IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC C-V</b>   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIS</b>  |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

|   |   |  |   |
|---|---|--|---|
| 19a. DATE OF OPERATION:   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/27/79</b> to <b>2/1/84</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/23/84</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death. |   |  |   |
| 22b. SIGNATURE<br><b>J. Braxton</b>   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. BRAXTON</b>  | 22e. ADDRESS<br><b>7432 PARK HTS AVE</b>  |  |   |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>Burial</b>                          | 23b. DATE<br><b>2-4-83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Relex Hill Gardens</b>                                 | 23d. LOCATION<br>CITY OR TOWN <b>BALTO, MD</b> COUNTY <b>BALTO</b> STATE <b>Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>Chas. H. Powell</b> ADDRESS <b>3147 Schroeder St</b> |                            | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Cawth</b> |   |

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Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified of such.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

BP



Handwritten signature or text at the bottom left.

1964 FEB 8



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified of cause.

6

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 4 3 9 9

REG. NO.

|   |  |   |  |  |   |  |  |  |   |  |  |
|---|--|---|--|--|---|--|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Gladys L. Sanborn   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 23 84 |  |  | 2b. HOUR<br>6 P M  |   |  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>02 05 15  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS                                      |  |  | IF UNDER YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>USA Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wyman Park Health System, Inc. |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home   |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |   |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis Wenk  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Gladys W. Millen  |   |  |  | 13e. STREET ADDRESS<br>1105 Ivywood Lane 21204   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>212 05 1948  |   | 17. INFORMANT<br>STANLY H. SANBORN   |  | ADDRESS<br>1105 Ivywood Lane   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br><u>Aortic Valvular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Rheumatic Heart Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Acute</u>    |  |   |  |  |   |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |  |  |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> , 19 <u>58</u> , to <u>2/23</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased above <u>1/23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |  |  |   |  |  |
| 22b. SIGNATURE<br>Duncan Salmon MD  |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |   |  |  | 22c. DATE SIGNED<br>02/24/84   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Duncan Salmon  |  |   |  | 22e. ADDRESS<br>3100 Wyman Park Drive-Baltimore, MD 21211  |   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2/27/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FR LINCOLN   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood Prince Georges MD      |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Rock inc   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1984   |   | 25b. REGISTRAR'S SIGNATURE   |  |  |   |  |  |

MEDICAL CERTIFICATION

584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04400

REG. NO.

|   |  |  |   |  |               |  |  |         |
|---|--|--|---|--|---------------|--|--|---------|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | MONTH  | DAY           | YEAR   | 2b. HOUR                                     |         |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  | MIDDLE  | LAST   |               |  |  |         |
| ADDIE   |  | -  |   | SAVAGE   | 02 19 84      |  |  | 2:30 AM |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |               | IF UNDER 1 YEAR  |  |         |
| FEMALE  | BLACK  | MONTH DAY YEAR   |   | 77 YRS.  |               | IF UNDER 24 HRS.   |  |         |
|   |  | 10 24 06   |   |  |               | MONTHS DAYS HOURS MIN.   |  |         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |               |  |  |         |
| Georgia   | USA  |  |   | BALTIMORE CITY MD.   |               |  |  |         |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |               | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |         |
| Baltimore   | Sinai Hospital   |  |   | Housewife  |               |  |  |         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 13b. STATE   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |               |  |  |         |
| md  | -  | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3728 Park Hgts Ave   |               |  |  |         |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   |  |   |  |               |  |  |         |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST  |  |   |  |               |  |  |         |
| Robert Russell  | Lola Dunlap  |  |   |  |               |  |  |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  |   | ADDRESS  |               |  |  |         |
| NO  | -  | 219-12-7231  |   | James W. Sligh - 3728 Park Hgts Ave  |               |  |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |
| PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |               |  |  |         |
| IMMEDIATE CAUSE (a) RESPIRATORY ARREST  |  |  |   |  |               |  | 5 minutes                                    |         |
| 5999  |  |  |   |  |               |  |  |         |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |               |  |  |         |
| (b) SEPSIS  |  |  |   |  |               |  | 15 hours                                     |         |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |               |  |  |         |
| (c) UNKNOWN: PROBABLE URINE   |  |  |   |  |               |  | 7 days                                       |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |  |               |  |  |         |
| S/P ARDS - ASCVD ; CHRONIC GI. BLEED.   |  |  |   |  |               |  |  |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |         |
|   |  |  |   | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>   |               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |               |  |  |         |
|   |  | P.M. 19  |   |  |               |  |  |         |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |               |  |  |         |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   | STREET CITY OR TOWN COUNTY STATE   |               |  |  |         |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12, 1984, to 2/19, 1984, that (I) (we) last saw the deceased alive on 2/19, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |               |  |  |         |
| 22b. SIGNATURE  |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |               | 22c. DATE SIGNED   |  |         |
| Douglas G. Martz Jr.  |  |  |   |  |               | 02/19/84   |  |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |               |  |  |         |
| DOUGLAS G. MARTZ JR.  |  | SINAI HOSPITAL OF BALTIMORE  |   |  |               |  |  |         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION |  |  |         |
| Burial  |  | 2-25-84  | Arbutus Mem. Pk Arbutus   |  | Balt. Md      |  |  |         |
| 24. FUNERAL DIRECTOR  |  | NAME   |   | ADDRESS  |               | 25a. DATE REC'D BY REGISTRAR                                   |  |         |
| Ludlow Carroll  |  | Purnell Adew   |   | Balt. Md   |               | 25b. REGISTRAR'S SIGNATURE                                     |  |         |
|   |  |  |   |  |               | FEB 27 1984  |  |         |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04401

|   |   |   |   |
|---|---|---|---|
| 1. FOR STATE REGISTRAR  |   | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT) <b>EUGENE SAUNDERS</b>   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2/5 84</b>  |   |
| 3. SEX <b>male</b>  | 4. RACE <b>Black</b>  | 5. DATE OF BIRTH MONTH DAY YEAR <b>09/15/19</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Unknown</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SEDA HOSPITAL</b> | 12a. USUAL OCCUPATION (TYPE, COUNTRY, OR INDUSTRY WORKING LIFE) <b>Unknown</b>  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE <b>MD</b>  | 13b. COUNTY   | 13c. CITY OR TOWN <b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Charlie Saunders</b>   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   | 16b. SOCIAL SECURITY NO. <b>224 078 706</b>   |
| 17. INFORMANT ADDRESS <b>MRS Thelma Trent 2134 Ynt Holly St</b>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |
| PART 1. DEATH WAS CAUSED BY:  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| IMMEDIATE CAUSE (a) <b>Pneumonia</b>  |   | <b>3 wks</b>  |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Left Atherosclerosis of Left lower lung</b>   |   | <b>3 wks</b>  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Complications of lung</b>   |   | <b>6 mo</b>   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension, COPD</b>  |   |   |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>01/22 1984</b> to <b>2/5 1984</b> , that (1) (we) lost <b>saw the deceased alive on 2/5 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |   |   |   |
| 22b. SIGNATURE <b>Vermont</b>   | DEGREE  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                          | DATE SIGNED <b>2/5</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VERMONT</b>  | 22e. ADDRESS <b>9124 200 Homewood Terr BALTO MD</b>   | 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |   |
| 23b. DATE <b>2-10-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Cem</b>   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>   | 23e. DATE REC'D. BY REGISTRAR <b>FEB 15 1984</b>  |
| 24. FUNERAL DIRECTOR (TYPE OR PRINT) <b>Joseph Luss</b>   |   | 25. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>   |   |



Black 1911

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04402

REG. NO.

|   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                               |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |  |  |
| SHAWN Dale SCAFIDE  |  |  | 02/22/84  |  |  | 8:02pm  |  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  |  | 7. IF UNDER 1 YEAR  |  |  |
| Male  | Caucasian  | August 26 1969   | 14 YRS.   |  |  | MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                         | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |   |  |  |
| Washington, D.C.  | U.S.A.   |  | BALTIMORE CITY MD.  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL   |  | Student   |  |  |   |  |  |
| 13a. STATE  |  |  | 13b. CITY OR TOWN   |  |  | 13c. INSIDE CITY LIMITS?  |  |  |
| Maryland  |  |  | Montgomery  |  |  | Wheaton YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |  | 13d. STREET ADDRESS   |  |  |
| Gasper Joseph Scafile   |  |  | Connie G. Peters  |  |  | 2660 Cory Terrace 20902   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  |  | 16b. SOCIAL SECURITY NO.                                      |  |  | 17. INFORMANT   |  |  |
| No  |  |  | 212-86-9698   |  |  | Gasper Joseph Scafile Father Same as 13                                     |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE                              |  |  |  |
| 2028  |  | 1 YR   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (b) T-CELL LYMPHOMA   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c)   |  |  |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RADIO-THERAPY  
THORACIC MASS, POSSIBLE MYOCARDIAL DAMAGE FROM CHEMOTHERAPY

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR                         |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY                             |  | 21f. LOCATION  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)    |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from MARCH 1, 1983, to FEB 22, 1984, that (I) lost saw the deceased alive on FEB 22, 1984, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| PETER ROWE   |  | MD   |  |  |  | 2-22-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS                                     |  |  |  |  |  |
| PETER ROWE   |  | c/o JOHNS HOPKINS HOSP.                          |  |  |  |  |  |

|  |               |                                    |                         |
|--|---------------|------------------------------------|-------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE     | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION           |
| Burial                                     | Feb. 25, 1984 | Gate of Heaven                     | Silver Spring Mont. Md. |
| 24. FUNERAL DIRECTOR                       |               | 25a. DATE REC'D. BY REGISTRAR      |                         |
| Francis J. Collins                         |               | FEB 27 1984                        |                         |
| 500 University Blvd. W. Silver Spring, Md. |               | 25b. REGISTRAR'S SIGNATURE         |                         |
|  |               | [Signature]                        |                         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





500 University Blvd., N. Silver Spring, Md.  
Francis J. Collins  
Feb. 25, 1962, Care of Branch

2019-2020



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| FOR<br>1 - STATE<br>REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Helen L. Scarfield</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 29, 1984</b>   |  |  |  | 2b. HOUR<br><b>12:50 PM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 28, 1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>63</b>  |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>12:50 PM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                 |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pickling</b> |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>6704 O'Donnell St. #21224</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Smolinski</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Cadomski</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>  |  | 17. INFORMANT<br><b>Joseph P. Scarfield-</b>  |  |  |  | ADDRESS<br><b>6704 O'Donnell St.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>arteriosclerotic coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>---</b> <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)     |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 64</b> to <b>22 Feb - 19 84</b> , that (I) (we) last saw the deceased alive on <b>22 Feb - 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Salvatore J. DeMarco</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1 Mar 84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Salvatore DeMarco III</b>  |  |  |  | 22e. ADDRESS<br><b>333 St. Paul Street</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>3/3/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cem.</b>                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George A. Weber &amp; Sons Inc.</b>   |  |  |  |   |  | ADDRESS<br><b>- 705 S. Ann St.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>1984</b>   |  | 25b. REGISTERED PHYSICIAN<br><b>Salvatore J. DeMarco</b>   |  |

BP

SECRET  
CONFIDENTIAL

1. The purpose of this document is to provide information regarding the activities of the [redacted] organization. This information is being provided to you for your information only and is not to be distributed outside of your organization.

2. The information contained herein is classified as [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

3. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

4. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

5. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

6. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

7. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

8. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

9. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

10. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

11. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

12. This document contains information that is [redacted] and is to be handled accordingly. It is the policy of the [redacted] organization to protect this information from unauthorized disclosure.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |   | REG. NO. 04404  |  |
|---|--|---|--|---|--|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>May N. Schaech</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 22, 1984</b>  |  |   | 2b. HOUR<br><b>7:10 PM</b>  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 23, 1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                     |   | IF UNDER 72 HRS   |  |
| 7a. BIRTHPLACE (COUNTRY)<br><b>Russia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>   |  |   | 12b. IN <input type="checkbox"/> OR <input checked="" type="checkbox"/> |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  |   |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Gregory Nowitsky</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Anna Denisoff</b>   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>219-18-9457</b>  |  | 17. INFORMANT<br><b>A Mary Miglioretti, 2014 Dumont Rd,</b>  |  |   | ADDRESS<br><b>Timonium, Md. 21093</b>                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b><br><b>1790</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Adenocarcinoma of the Uterus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <b>February 15, 19 84</b> to <b>February 22, 19 84</b> , that (x) (we) lost<br>saw the deceased alive on <b>February 22, 19 84</b> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated<br>above (x) (we) (did) (not) view the body after death. |  |   |  |   |  |  |  |   |   |   |  |
| 23a. SIGNATURE<br><b>Stanley T. Prince, M.D.</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 23b. DATE SIGNED<br><b>2/23/84</b>                                      |   |  |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stanley T. Prince, M.D.</b>   |  |   |  |   |  | 23d. ADDRESS<br><b>C/O Maryland General Hospital</b>   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>   |  |   |  | 23b. DATE<br><b>2/25/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto, Md.</b>         |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SCHIMUNEK FUNERAL HOME, INC, 3331 Brehms La,</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>Feb 24 1984</b>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>              |   |  |

7:10P

February 22, 1967

Concord

May

Baltimore City

Maryland General Hospital

Baltimore

Local Baltimore Area

Advertisement of the Bureau

February 22, 64

84

February 12

84

February 22

84

C/O Maryland General Hospital

Stanley T. Prince, M.D.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04405

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George C. Scheffer</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 4, 1984</b>                            |  | 2b. HOUR<br><b>6:30 A.M.</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 17 1891</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4304 Arabia Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Photo Engraver</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sterling Engraving Co.</b>                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b> |  |   | 13b. COUNTY<br><b>-</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles J. Scheffer</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anne Schissler</b>                    |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>            |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-2514</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Rose Scheffer (wife) same address</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Metastatic Carcinoma of Stomach.**

1519  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION<br><b>March '82</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Stomach.</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)          |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>76w Osler Drive Balto. Md.</b> |   |
| 22a. I certify that (I) (this <b>Dr. Hans Koetter</b> attended the deceased from <b>Feb 17 Nov 83</b> to <b>4 Feb 84</b> , that (I) (we) last saw the deceased alive on <b>17 Nov 83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Dr. Hans Koetter</b>   |  | 22c. DATE SIGNED<br><b>6 Feb 84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Hans Koetter</b>  |  | 22e. ADDRESS<br><b>76w Osler Drive</b>   |   |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>  | 23b. DATE<br><b>2/7/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Mausoleum</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Schimunek Funeral Home, Inc.<br/>3331 Brehms Lane, Balto. Md. 21213</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 7 1984</b>              | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "exempt," the medical examiner may be notified at once.

(1)



Metabolic conversion of starch

March 23 Conversion of starch

X



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 4 4 0 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Lillian C. Schempp</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>February 24, 1984</i>                                  |  | 2b. HOUR<br><i>3 P.M.</i>                 |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>March 26, 1899</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>84</i> YRS.                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore, Md.</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City, MD.</i> |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>24 N. Clinton Street</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Tavern Owner - Tavern</i> | 12b. KIND OF BUSINESS OR INDUSTRY                                  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Md.</i> 13b. COUNTY <i>---</i> 13c. CITY OR TOWN <i>Baltimore</i> |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><i>21224. 24 N. Clinton Street</i>          |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Anthony --- Klima</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Sophia --- Hadek</i>                         |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i> (IF YES, GIVE WAR OR DATES)   |  |   | 16b. SOCIAL SECURITY NO.<br><i>213-54-0708</i>   |  |   |
|  |  |   | 17. INFORMANT <i>Baltimore, Md. 21224</i><br><i>Frederick H. Buttner-721 S. 49th St</i>          |  |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ARTERIOSCLEROTIC CARDIOVASC. DIS.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>104 years</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>SUDDEN</i> |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/69</i> , 19 <i>76</i> , to <i>2/24</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>4/12/83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><i>Irwin B. Kaplan MD</i>   | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><i>2/25/84</i>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Irwin B. Kaplan MD</i>  | 22e. ADDRESS<br><i>129 S. BROADWAY 21231</i>                           |  |  |

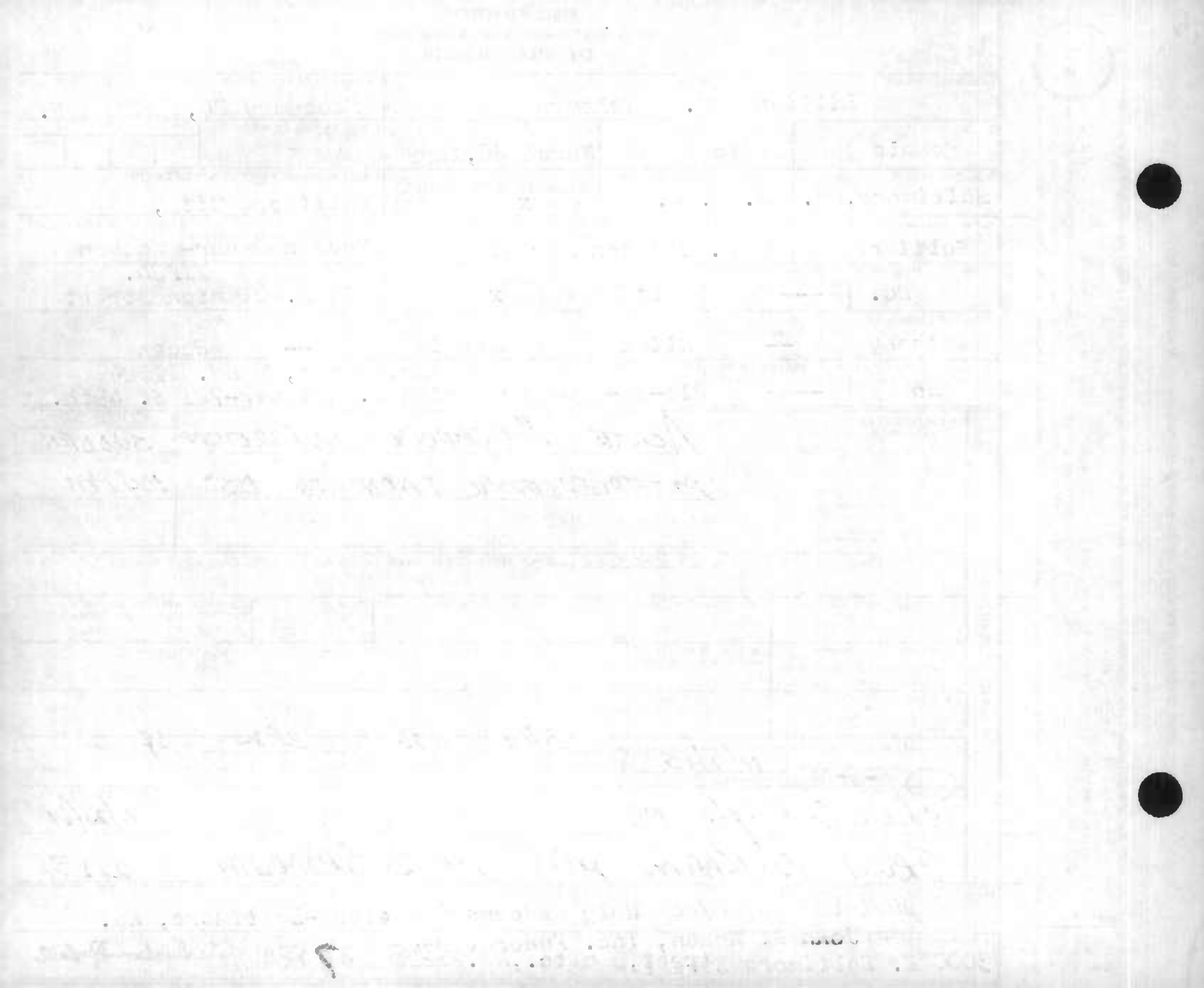
|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>              | 23b. DATE<br><i>2/28/84</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer Cemetery-Baltimore, Md.</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John A. Moran, Inc. Funeral Home</i> |                             | 25. DATE REC'D. BY REGISTRAR<br><i>FEB 27 1984</i>                                 | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i> |
| 3000 E. Baltimore Street, Balt., Md. 21224                              |                             |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer should be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04407

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>FIRST <i>Schulnick Morris</i> MIDDLE <i>Schoolnick</i> LAST <i>Schoolnick</i> |  |  | 2a. DATE OF DEATH MONTH <i>2</i> DAY <i>-10</i> YEAR <i>-84</i> |  |  | 2b. HOUR <i>10:55 PM</i>   |  |
| 3. SEX <i>MALE</i>  |  | 4. RACE <i>WHITE</i>   |   | 5. DATE OF BIRTH MONTH <i>12</i> DAY <i>24</i> YEAR <i>1900</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto Md</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto - XXXX</i> CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Levindale Geriatric Center</i> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SELF EMPLOYED</i>                     |  |
|   |  |  |   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>GROCERY</i>   |  |
| 13a. STATE <i>MARYLAND</i>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN <i>BALTIMORE</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |
| 14. FATHER'S NAME FIRST <i>SIMON</i> MIDDLE LAST <i>SCHOOLNICK</i>                                |  | 15. MOTHER'S MAIDEN NAME FIRST <i>BESSIE</i> MIDDLE LAST <i>UNKNOWN</i>  |   | 13e. STREET ADDRESS <i>6939 GLENHEIGHTS RD. 21215</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>                       |  | 16b. SOCIAL SECURITY NO. <i>215-03-1107</i>  |   | 17. INFORMANT ADDRESS <i>MRS. ADA G. SCHOOLNICK 6939 GLENHEIGHTS RD. 21215</i>   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cardio-pulm. Arrest**4860*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b) *Prob. Pneumonia*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/10</i> to <i>2/10</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>2/10</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <i>N. Haroun</i>   |  |   |  | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <i>2/11/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NAVI HAROUN</i>  |  |   |  | 22e. ADDRESS <i>Levindale, Balto 21215</i>  |  |   |  |

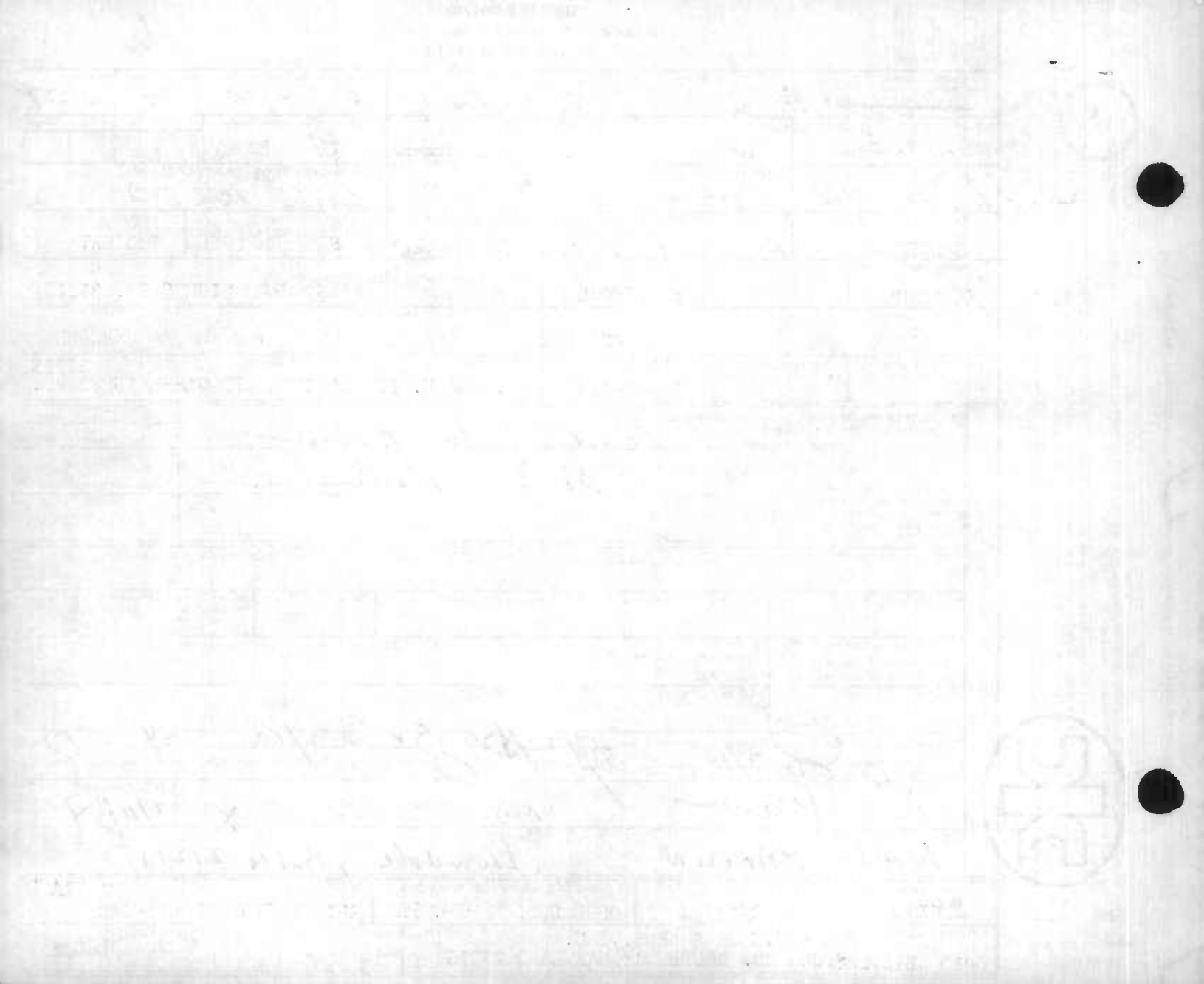
|   |  |                          |  |   |  |   |  |
|---|--|--------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> |  | 23b. DATE <i>2/12/84</i> |  | 23c. NAME OF CEMETERY OR CREMATORY <i>OHEB SHALOM MEM. PARK</i> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i> |  |
|---|--|--------------------------|--|---|--|---|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON &amp; BROS., INC.</i> |  | 25a. DATE REC'D. BY REGISTRAR <i>FEB 15 1984</i> |  | 25b. REGISTRAR'S SIGNATURE <i>Solia Davidson-Randall</i> |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215                 |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| FOR<br>1 - STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 04408   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARIE MARGARET SCHROEDER</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2/29/84</b>  |  | 2b. HOUR<br><b>11:40 AM</b>  |  |  |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>02 18 01</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.  |  | IF UNDER 1 YEAR<br>DAYS HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Catharine Hosp</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRESSER</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GARMENT</b>  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2106 WILHELM STREET, 21223</b>   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |   |  |  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>FREDERICK SCHROEDER</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARGARET UNKNOWN</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>213-05-0237</b>  |  | 17 INFORMANT ADDRESS<br><b>ANNA S. SCHROEDER 7802 SHELBOURNE RD. 21226</b>  |  |   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) MYO CARDIAC INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>---</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)<br><b>---</b>  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>---</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>---</b>   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>---</b>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>---</b>  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/29/84</b> to <b>2/29/84</b> , that (I) (we) last saw the deceased alive on <b>2/29/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                     |  | 22c. DATE SIGNED<br><b>2/29/84</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>[Signature]</b>  |  |   |  | 22e. ADDRESS<br><b>9051 BALTIMORE EC</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>03-03-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTERN CEMETERY</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY<br><b>BALTIMORE CITY MARYLAND</b>                             |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

BP

RECEIVED



STRICTLY CONFIDENTIAL

SECRET

CONFIDENTIAL

CONFIDENTIAL

SECRET

TO: THE SECRETARY OF THE ARMY, WASHINGTON, D. C.

FROM: THE SECRETARY OF THE ARMY, WASHINGTON, D. C.

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

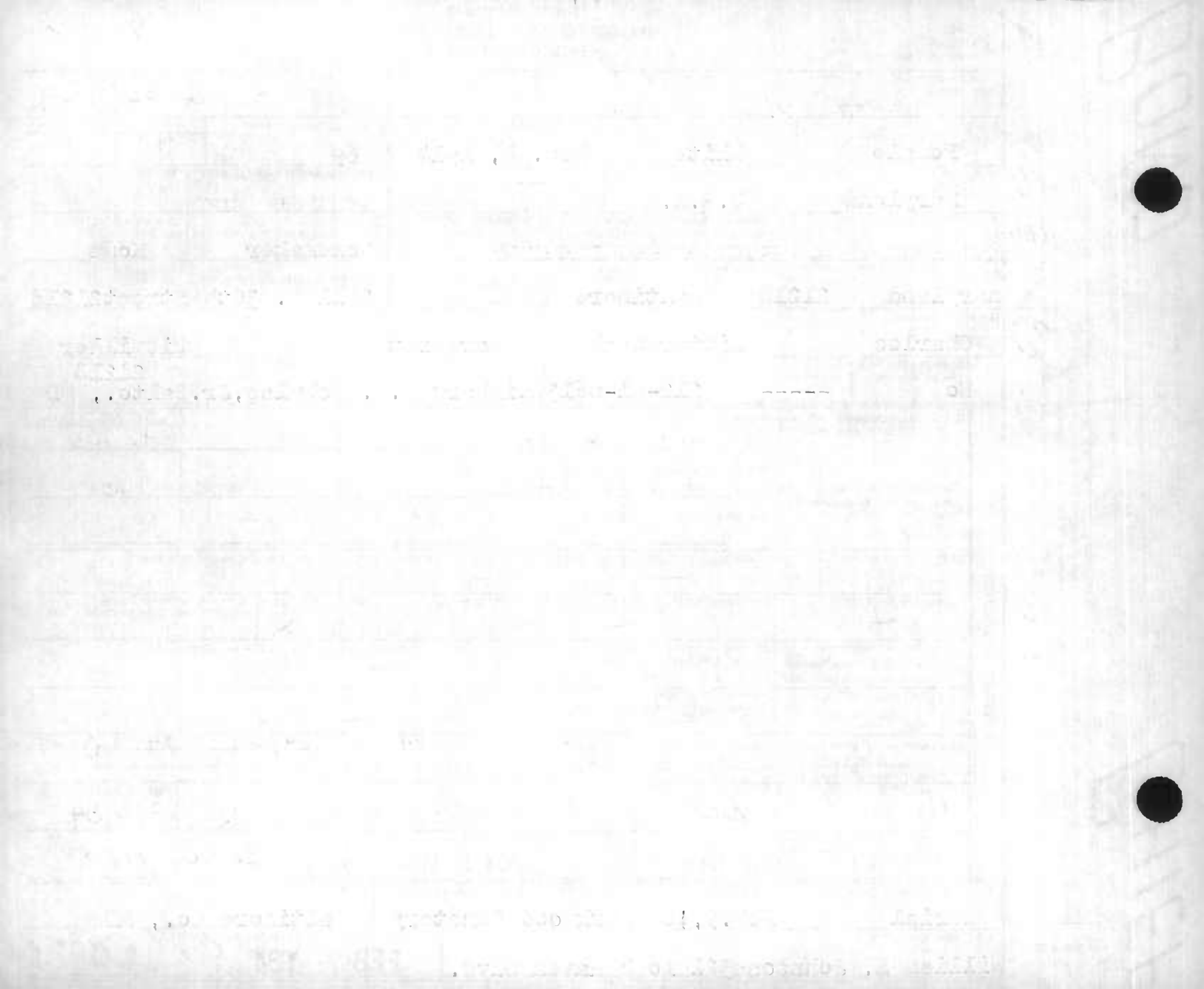
SECRET  
MAR 2 8 9AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 04409  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>DOROTHY M. SCHULZE   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>02 06 84  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 4, 1914  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>21218   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13e. STREET ADDRESS / ZIP CODE<br>2011 E. 30th Street 21218  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Ritterpusch   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Biemiller   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----   |  | 17. INFORMANT ADDRESS<br>21218<br>Reinhard C.H. Schulze, Jr. Balto., MD   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) massive @ CVA<br>4273<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) atrial fibrillation<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>~72 hrs<br>yrs |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19 —   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>— — — —  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/3 19 84 to 2/6 19 84, that (I) (we) last saw the deceased alive on 2/6 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Margaret M. Vaughan   |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>2/6/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARGARET VAUGHAN   |  |  |  | 22e. ADDRESS<br>201 E UNIV PKWY BALTO, 21218  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb. 9, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>William E. Johnson 8521 Loch Raven Blvd.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>FEB 7 1984 John J. Carver   |  |  |  |



## MEDICAL CERTIFICATION

NO. 1-12-1904 NEW JERSEY

RECEIVED

NOV 24-1904

RECEIVED



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04412

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE A LAST SEFF                            |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 1 84 |   |  | 2b. HOUR<br>6:30 P.M.   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 30 18  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Cancer Center                     |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore |   |   |  |   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>6517 WICKFIELD ROAD 21209   |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST Isaac MIDDLE LAST Cohen  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Rebecca MIDDLE LAST Fleet   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>NO               |  | 16b. SOCIAL SECURITY NO.<br>218-073059  |   | 17. INFORMANT<br>ADDRESS<br>Albert Seff 6517 WICKFIELD RD. 21209  |  |   |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>2028 IMMEDIATE CAUSE (a) Cardiac Arrhythmia |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>immediate |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Large Cell Lymphoma  |  | 3 weeks  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) Peritonitis  |  | 6 weeks  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

~~Stroke~~ Persistent Thrombocytopenia secondary to progressive lymphoma

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br>12/2/83 1/1/84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gastrectomy for Gastric Ulcer, Drainage of Hematomas |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |

22a. I certify that (I) (this hospital) attended the deceased from Nov 12, 1983, to Feb 1st 1984, that (I) (we) last saw the deceased alive on Feb 1st 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 22a. SIGNATURE<br>Thomas E Teufel                        |  | DEGREE   |  | 22c. DATE SIGNED<br>2/1/84  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas E Teufel |  | 22e. ADDRESS<br>22.5 Green Street Baltimore Maryland |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |

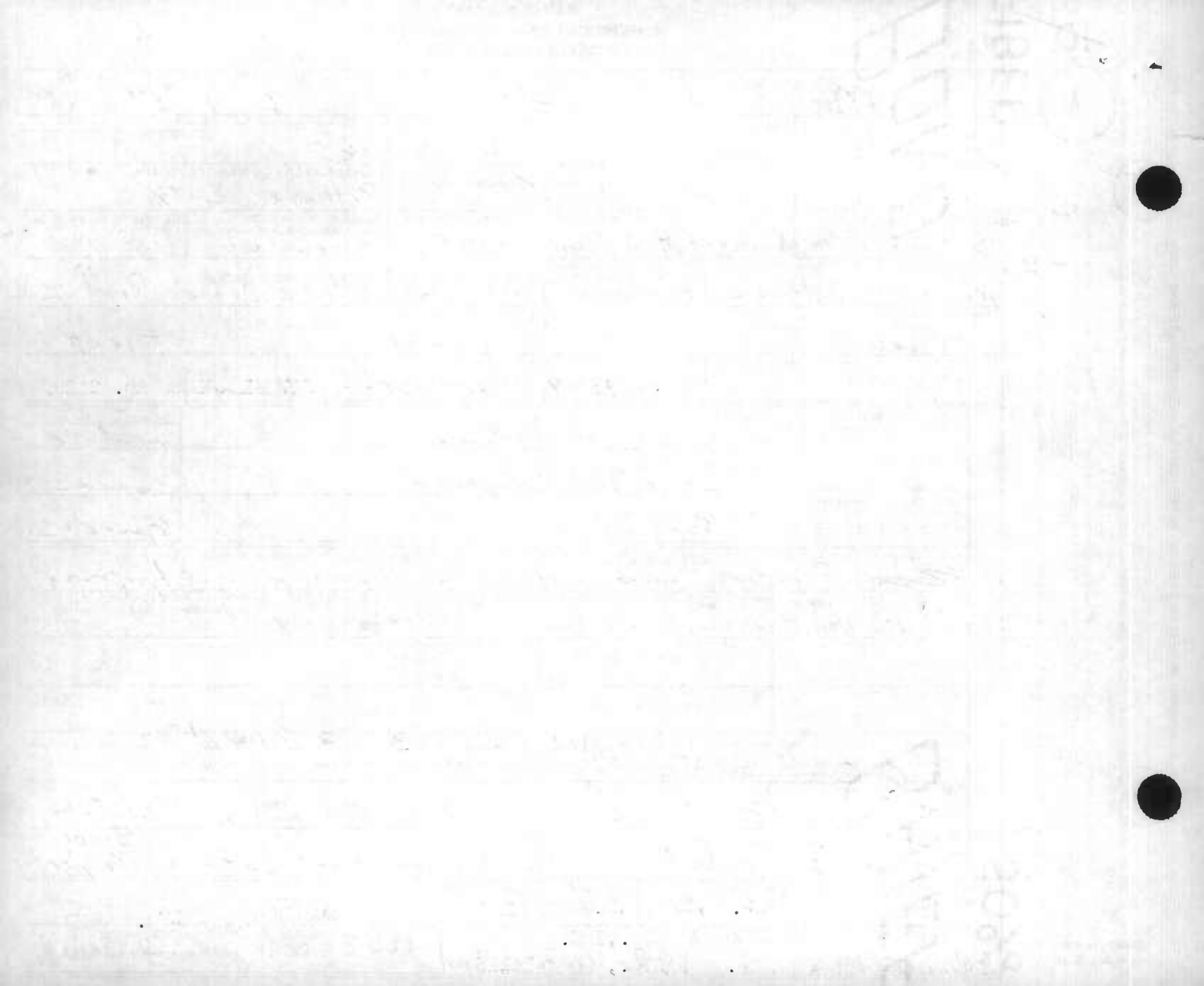
|  |  |                           |  |  |  |  |  |
|--|--|---------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  | 23b. DATE<br>FEB. 3, 1984 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SHAAREI ZION |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 56010 REISTERSTOWN RD. BALTO., MD 21215 |  |                           |  | 25a. DATE RECEIVED BY REGISTRAR<br>FEB 8 1984      |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Carver   |  |                           |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18, 19a, or 19b is marked, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04413

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HERBERT F. SEITZ</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 16, 1984</b> |  | 2b. HOUR<br><b>3:30 P<sub>M</sub></b>                          |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 3 09</b>   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>            |   | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                          |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5508 Minnoka Av. 21215</b> |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chemical</b>                   |   | 12c. STREET ADDRESS / ZIP CODE<br><b>5508 Minnoka Av. 21215</b>  |  |  |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Franklin Herbert Seitz</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Wilhelm</b>   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                               |  |  |
| 17. INFORMANT<br><b>Rachel E. Seitz</b>  |  | 18. SOCIAL SECURITY NO.<br><b>214-16-5518</b>                          |   | 19. ADDRESS<br><b>5508 Minnoka Av. 21215</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 years</b>  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 mins.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>78</b> , to <b>Feb</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 8</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Ira A. Morris M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |   | 22c. DATE SIGNED<br><b>2/16/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ira A. Morris M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>4419 Falls Rd.</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/21/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion</b>  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Freeland Balto.Co. Md.</b>  |  | 24. FUNERAL DIRECTOR<br><b>William E. Johnson</b>                      |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1984</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  | 25c. REGISTRAR'S SIGNATURE   |   |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 04414  |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>Minnie Seitz</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>February 6, 1984</b>                                     |  |  |  | 2b. HOUR <b>10:15 AM</b>  |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Caucasin</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 15 04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.   |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Babysitter</b>              |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Silverman</b>  |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>301 McMeeekin Street 21217</b>           |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>William Seitz</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara Horner</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO. <b>_____</b>   |  | 17 INFORMANT ADDRESS <b>Balto, Md 21227</b><br><b>Ernest Seitz 6295 Rockburn Hill Road</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypothermia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)               |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 6, 1984</b> to <b>February 6, 1984</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>February 6, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Mania Teresa Curras</b> MD   |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>Feb 7/84</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mania Teresa Curras</b>   |  |   |  | 22e. ADDRESS <b>c/o Maryland General Hospital</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |   |  | 23b. DATE <b>2-7-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>                                   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>  |  |
| 24 FUNERAL DIRECTOR NAME <b>MacNabb Funeral Home</b>   |  |   |  | ADDRESS <b>Catonsville, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 9 1984</b> 25b. REGISTRAR'S SIGNATURE |  |   |  |

February 6, 1934

Police

Chicago

Baltimore City

Harland General Hospital

Baltimore

Cardiac Clinic

Harland General Hospital

February 6, 34

February 6, 34

XX

Harland General Hospital

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER'S OFFICE BY TELEPHONE OR IN WRITING. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PREPARATION OF A BURIAL PERMIT. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHOUT SIGNATURES, WITHIN 24 HOURS OF RECEIPT. PAGES 1 AND 2 SHOULD BE FILED, WITHOUT SIGNATURES, WITH VITAL RECORDS, 201 W. PRINCETON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

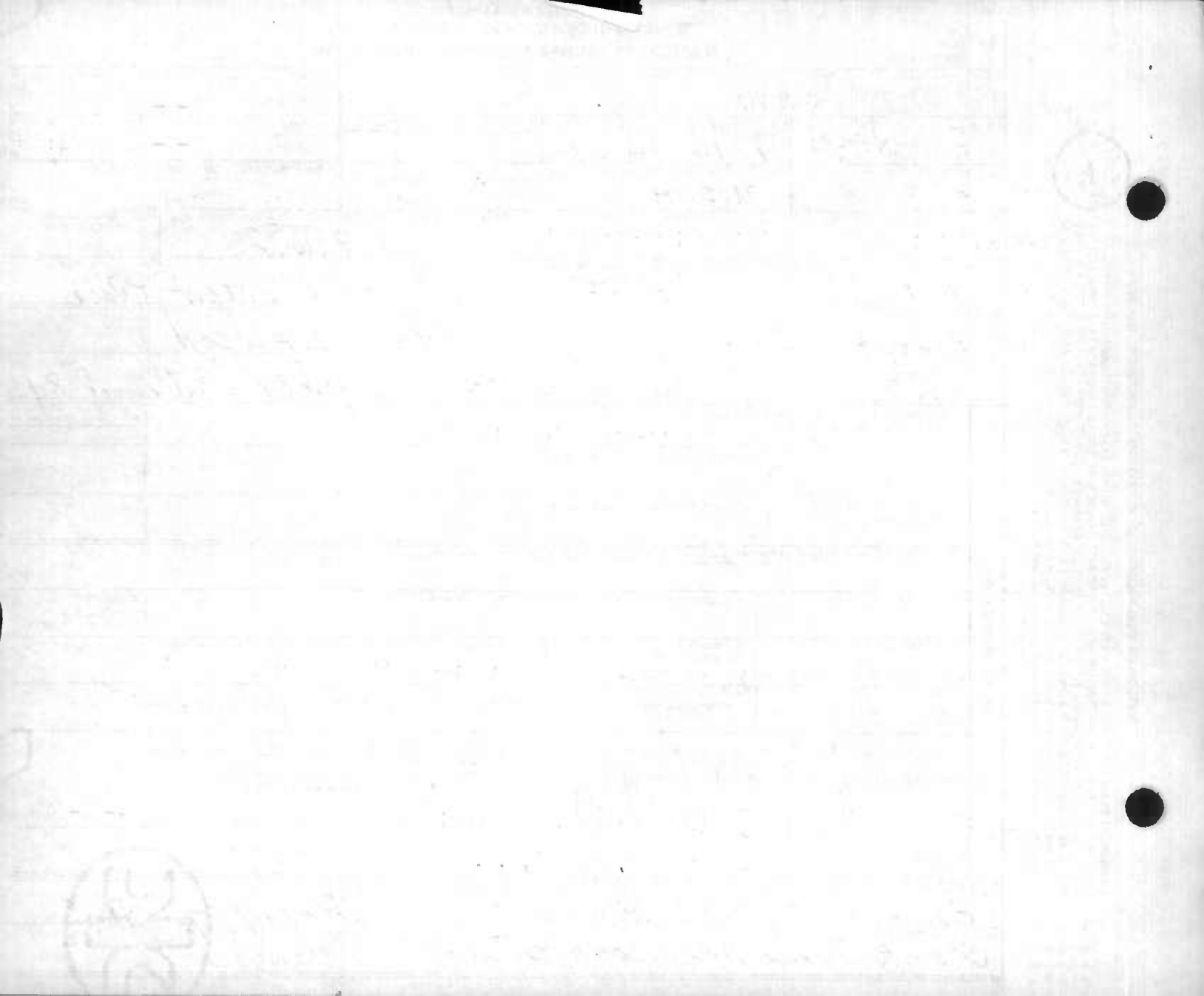
BP\_\_\_\_\_

DHMH - 17

(VR A15 ME (5))

20M 4/82

|  |  |   |  |   |  |                                   |  |  |  |                          |  |
|--|--|---|--|---|--|-----------------------------------|--|--|--|--------------------------|--|
| 1- FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  | 04415<br>REG. NO.                 |  |  |  |                          |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST                              |  | 2a. DATE KNOWN OF DEATH                      |  | 2b. HOUR                 |  |
| JUANITA  |  | B.  |  | SELPH   |  |                                   |  | 2-9-84 19                                    |  | M                        |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 24 HRS.                          |  | 2c. DATE PRONOUNCED DEAD |  |
| F  |  | NEGRO   |  | 1 16 16   |  | 68 YRS.                           |  | MONTHS DAYS HOURS MIN                        |  | 2-9-84 19 3:50P M        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED  |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  | MD                       |  |
| S.C.   |  | U.S.A   |  | WIDOWED   |  | DIVORCED                          |  | Baltimore City                               |  |                          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |                          |  |
| Baltimore  |  | University Hospital   |  | Retired   |  |                                   |  |  |  |                          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                     |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                 |  | 13d. INSIDE CITY LIMITS?                     |  | 13e. STREET ADDRESS      |  |
| Md.  |  |   |  | Balt.   |  | YES NO                            |  | 2217   |  | 2216 Eutaw Place         |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  | 16b. SOCIAL SECURITY NO.          |  | 17. INFORMANT                                |  | ADDRESS                  |  |
| Reddick  |  | EHA LAWSON  |  | NO  |  | Not Available                     |  | Rose Munford                                 |  | 3816 Battlewood Rd       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART 1 DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |
| 9800   |  |   |  | Salicylate intoxication   |  |                                   |  |  |  |                          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                  |  |   |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF    |  |  |  |                          |  |
|  |  |   |  | (c)   |  |                                   |  |  |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |  |   |  |   |  |                                   |  |  |  |                          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?  |  | YES NO                            |  |  |  |                          |  |
|  |  |   |  | YES NO  |  |                                   |  |  |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                   |  |  |  |                          |  |
| XOR  |  | ? P.M. 2-9-84 19  |  | ingestion of drugs  |  |                                   |  |  |  |                          |  |
| 21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION   |  | CITY OR TOWN                      |  | COUNTY                                       |  | STATE                    |  |
| XX   |  | home  |  | 2216 Eutaw Place  |  | Baltimore, Maryland               |  |  |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                 |  | Autopsy XXX Inspection Inquiry and in my opinion  |  |   |  |                                   |  |  |  |                          |  |
| Natural causes Accident Suicide Homicide Undetermined manner   |  |   |  |   |  |                                   |  |  |  |                          |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |  | DATE SIGNED   |  |                                   |  |  |  |                          |  |
| Margarita A. Korell, M.D.  |  | Assistant MEDICAL EXAMINER  |  | 2-10-84   |  |                                   |  |  |  |                          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS   |  |   |  |                                   |  |  |  |                          |  |
| Margarita A. Korell, M.D.  |  | 111 Penn Street   |  |   |  |                                   |  |  |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION                     |  | COUNTY                                       |  | STATE                    |  |
| Removal  |  | 2/14/84   |  | Hemmingway  |  | Hemmingway                        |  | D.C.   |  |                          |  |
| 24. FUNERAL DIRECTOR   |  | DATE REC'D. BY REGISTRAR  |  | REGISTRAR'S SIGNATURE   |  |                                   |  |  |  |                          |  |
| Locks Funeral Home   |  | FEB 14 1984   |  | Jana Davidson   |  |                                   |  |  |  |                          |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

04416

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT B. SEVIER</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 20, 1984</b>   |  |   |  | 2b. HOUR<br><b>2:15 PM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 23, 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Long Green Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Rogers Forge</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin B. Sevier</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Kahl</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1017 Regester Ave. - 21239</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-0756</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Bernadette M. Sevier - Same as #13e</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable pneumonia</b><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Senile dementia, <del>Alzheimer's disease</del> DDC</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 20, 1984</b> to <b>Feb. 20, 1984</b> , that (I) (we) lost saw the deceased alive on <b>Never seen by me</b> , and that (in (my) (our) opinion death occurred on the date and hour stated above, (I) (we) (did) (did not) view the body after death. <b>(Covers for Dr. Norman Freeman)</b>   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>David D. Collins</b> MD  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>2/21/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David D. Collins, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>500 W. University Pkwy. Balto., Md. 21210</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-23-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

BP

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

1050 York Rd.

Morland

Baltimore

Funeral

2-23-64

500 W. University Hwy. Balto., Md. 21210

David D. Collins, M.D.

No 217-01-0756 Bernadette M. Sevier - Same as #136

Benjamin

M.

Sevier

Marxist

Kahl

Maryland Baltimore Rogers Forge x 1017 Regester Ave. - 21229

Baltimore

Benjamin Long Green Nursing Home

Retired

Construction

Maryland

U.S.A.

Baltimore City

Male

White

March 23, 1927

SC

February 20, 1984

CIVILIAN

M.

Robert

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR Item 21athru 22a  
1- STATE REGISTRAR 3-13-84 cn

04417

|  |  |   |  |   |  |  |  |  |                             |
|--|--|---|--|---|--|--|--|--|-----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM VERNON SEWELL JR.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 18 84                                 |   |  | 2b. HOUR<br>4:32p M  |  |  |                             |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 25 24   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |                             |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER, BALTO., MD. 21218 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                             |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William V. Sewell, Sr.   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Barrett                  |   |  | 13e. STREET ADDRESS / ZIP CODE<br>1500 N. Port Street 21213                          |  |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-18-1649         |   | 17. INFORMANT ADDRESS<br>Gladys Sewell 1500 N. Port Street                             |  |  |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>8880<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Subdural And Epidural Hematoma Surgery</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>AFALL</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>9 days</u><br><u>15 days</u> |  |   |  |   |  |  |  |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alcoholic Liver Disease</u>  |  |   |  |   |  |  |  |  |                             |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1 P.M. 2-9-84 19            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>Fall |  |  |  |                             |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Home |   | 21f. LOCATION<br>STREET<br>Baltimore   |  | CITY OR TOWN<br>Baltimore  |  | STATE<br>Md                 |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 15, 19 84, to FEBRUARY 18, 19 84, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEBRUARY 18, 19 84, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.<br><u>Accident</u>                                |  |   |  |   |  |  |  |  |                             |
| 22b. SIGNATURE<br>Michael J. Buchanan  |  |   |  |   | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/18/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL J. BUCHANAN   |  |   |  |   | 22e. ADDRESS<br>NAME BALTIMORE, MD 21218   |  |  |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>2/23/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA                               |  | 23d. LOCATION<br>CITY OR TOWN<br>Owing Mills, MD.  |  |                             |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue  |  |   |  |   | 25. DATE REC'D BY REGISTRAR<br>FEB 21 1984   |  | 26. REGISTRAR'S SIGNATURE<br>[Signature]   |  |                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

immediate

1949

12 days

CONFIDENTIAL - SECURITY MATTER

Subject and to be held in confidence - 1949

ATLAS

CONFIDENTIAL - SECURITY MATTER

1

8/12/54

MD

Michael J. Buchanan

Director, FBI, Bureau

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0-4 4 1 8

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| MILDRED SHANKLIN   |  |   |  | 2/ 11 / 1984  |  | 9.25 A.M.   |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  |
| Female   |  | White   |  | June 6, 1909  |  | 74 YRS.   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>COUNTRY  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| MD   |  | USA   |  |   |  | Baltimore City MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore  |  | Good Samaritan Hospital   |  | Teacher   |  | Education   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| MD   |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3502 Hamilton Ave. 21214                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |
| J. S. Reese Shanklin   |  |   |  | Annabelle Gontrum   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |   |  |  |  |
| No   |  | 214 38 3575   |  | Joshua W. Miles, Balto., MD   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br><u>4151</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CONGESTIVE HEART FAILURE, Pul. edema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Pulm. embolism</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
|  |  |   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/21</u> , 19 <u>84</u> , to <u>2/11</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>C. Das MD</u>   |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><u>2-11-84</u>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>CHANDRANATH L. DAS</u>   |  |   |  | 22e. ADDRESS<br><u>24 DOWLING CIRCLE, B2, Baltimore, MD 21234</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |
| Burial   |  | 2/15/84   |  | Prospect Hill   |  | Towson, MD  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |  |   |  | FEB 14 1984   |  | John Davidson-Randall   |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

Page 1 of 1  
Date: 12/12/12  
Time: 10:10 AM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |   | REG. NO. 04419  |                                |  |                                |  |  |  |  |
|--|--|--|--|---|--|---|--|--|---|---|--------------------------------|--|--------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |   |   |                                | 2b. HOUR                                       |                                |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>EMMA C SHARP   |  |  |  |   |  | 2/15/84   |  |  |   |   |                                | 1 P.M.   |                                |  |  |  |  |
| 3. SEX<br>FEMALE   |  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>10/04/897               |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.   |   |   | 7. IF UNDER 1 YEAR MONTHS DAYS |  | 8. IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |   |                                |  |                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |   |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUB. TEACHER |   |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>EDUCATION |                                |  |  |  |  |
| 13a. STATE MARYLAND  |  |  |  |   |  |   |  |  |   | 13b. COUNTY HOWARD  |                                | 13c. CITY OR TOWN GLENWATOD                    |                                | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>3404 SHARP ROAD 21738 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WILLIAM GLORIUS   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>DELIA BYRNES |   |  |  |   |   |                                |  |                                |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |  |  |   | 16b. SOCIAL SECURITY NO.                                   |   |  |  |   | 17. INFORMANT ADDRESS<br>Ms. Mary B. Murphy 1800 Palo Circle<br>Baltimore, MD 21227   |                                |  |                                |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute renal failure<br>8842<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Fracture LEFT Hip<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cardiac insufficiency                   |  |  |  |   |  |   |  |  |   |   |                                |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |  |  |   |  |   |  |  |   |   |                                |  |                                |  |  |  |  |
| 19a. DATE OF OPERATION<br>2/14/84  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Fracture LEFT Hip               |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                |  |                                |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR<br>1 P.M. 2 6 1984                     |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 FIRST)<br>Subject fell from chair. |   |   |                                |  |                                |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>nursing home |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>98 Smithwood Rd., Catonsville, Balto., Md.   |   |   |                                |  |                                |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 2/15/84, 1984, to 2/15/84, 1984, that I (we) last saw the deceased alive on 2/15/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |   |   |                                |  |                                |  |  |  |  |
| 22b. SIGNATURE<br>Charles D. White MD  |  |  |  |   |  |   |  | DEGREE   |   |   |                                | 22c. DATE SIGNED<br>2/15/84                    |                                |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles D. White MD   |  |  |  |   |  |   |  | 22e. ADDRESS<br>P.O. Box 268<br>Baltimore City, MD 21203                                       |   |   |                                |  |                                |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |  |  |  | 23b. DATE<br>2-18-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. VIEW CEMETERY   |  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City, Md.  |                                |  |                                |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>SLACK FUNERAL HOME   |  |  |  |   |  |   |  |  |   |   |                                |  |                                |  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |   |  |  |  | REG. NO. 4420   |  |
|--|--|------------------|--|---|--|---|--|--|--|---|--|
| 1- STATE REGISTRAR   |  |                  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Alease Sabrina Shaw  |  |                  |  |   |  |   |  |  |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 2/22/84 19 |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug-8-63   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.                 |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2b. HOUR A M 4:47   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 2c. DATE PRONOUNCED DEAD 2/22/84 19   |  |
| 9. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food Shop                                    |  |
| 10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.  |  |                  |  | 13a. CITY OR TOWN<br>Baltimore  |  |   |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS<br>1507 N. Patterson Park Ave.                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Leo Shaw  |  |                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sylvia E. Makell  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>217/70/2310  |  |                  |  | 17. INFORMANT<br>Mrs. Sylvia Parker Patterson   |  |   |  | ADDRESS 1507 Patterson Park Ave.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) Methamphetamine Overdose<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |                  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.   |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>2/22/84   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |                  |  | ADDRESS<br>111 Penn St., Balto., Md. 21201  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>2-28-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park |  | 23d. LOCATION CITY OR TOWN<br>Arbutus  |  | COUNTY STATE<br>Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Randolph D. Collick   |  |                  |  | ADDRESS<br>2431 E. Oliver St.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randell                               |  |

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

04421

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Stanley</b><br><b>STANLEY</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 23, 1984</b>   |  | 2b. HOUR<br><b>8:21 A M</b>   |   |
| 3 SEX<br><b>MALE</b>   | 4 RACE <b>White</b><br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 20, 1909</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TENNESSEE</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.                                |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreman</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Carrlowsery</b> |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>AnneArundel</b>  | 13c. CITY OR TOWN<br><b>GlenBurnie</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Worley Shelton</b><br><b>SHELTON</b>  |  | 15. MOTHER'S NAME<br>FIRST MIDDLE LAST<br><b>Effie</b><br><b>EFFIE</b>   |  | 16. STREET ADDRESS / ZIP CODE<br><b>319 CHANEY LN 21061</b>                                     |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No N/A</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>408-14-4218</b>   |  | 17 INFORMANT (Wife) ADDRESS<br><b>Mrs. Laura Shelton- Same as #13</b>                           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1519</b> IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC ADENOCARCINOMA OF STOMACH</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-18</b> , 19 <b>84</b> , to <b>2-23</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-23</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Alan N. Dennis</b> MD   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>2/23/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan N. Dennis</b>   |  | 22e. ADDRESS<br><b>3001 S. Hanover St #83 Balto MD</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>Feb. 25, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Prk</b>                                |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1984</b>  |  |   |   |
| 24 FUNERAL DIRECTOR<br><b>Singleton Funeral Home</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

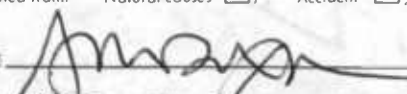

IMPORTANT: If item 21 is marked or item 18 is marked for any injury, or other traumatic event, the medical examiner must be notified of same.

BP

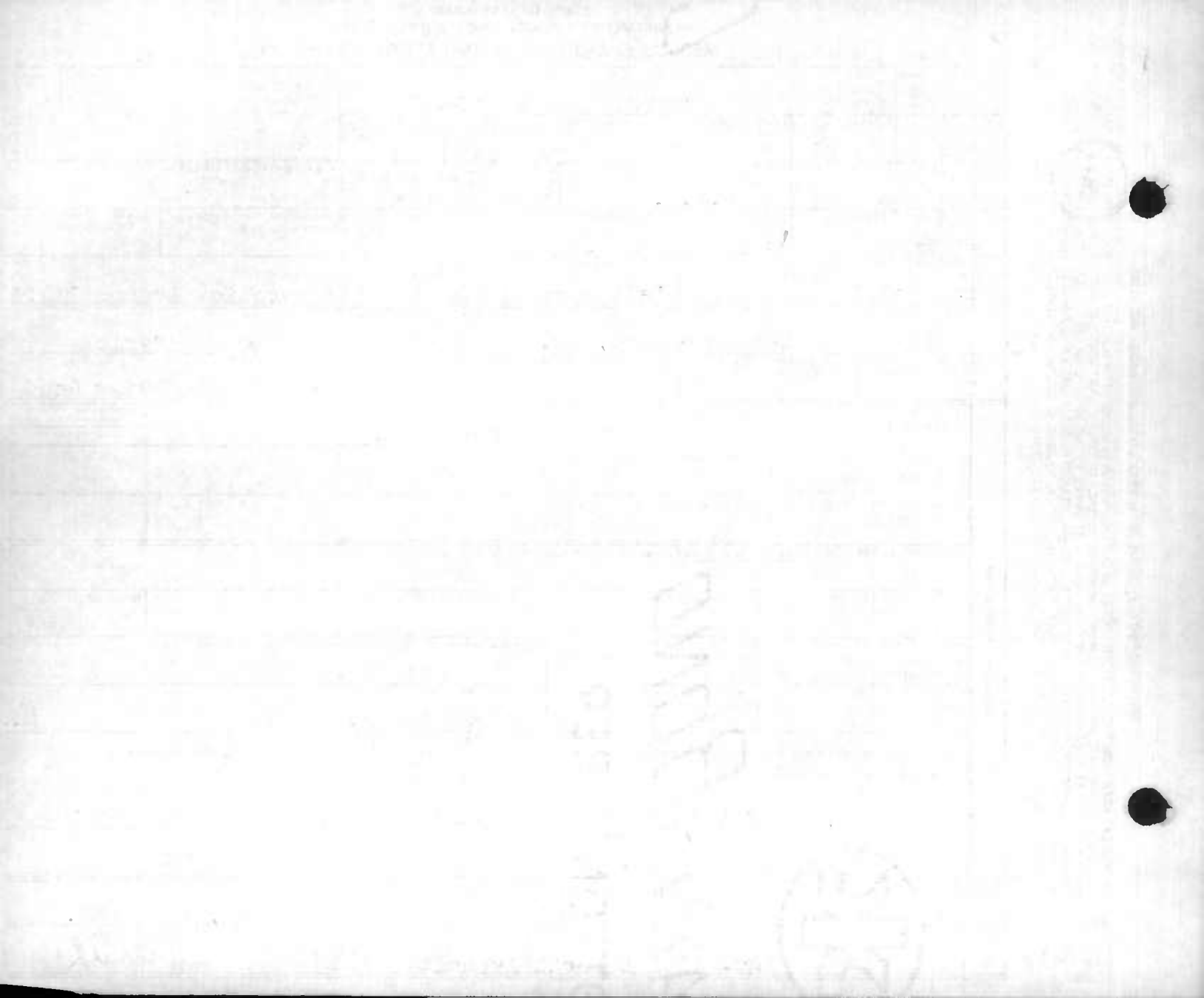
Handwritten notes and scribbles, including the word "Lecture" at the top and "Lecture 1" in the middle. The text is mostly illegible due to fading and bleed-through from the reverse side of the page.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |  |  |  |  | REG. NO. 4422  |  |
|--|--|----------------------|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEON THOMAS SHEPPARD</b>  |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>2</b> DAY <b>8</b> YEAR <b>1984</b> |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>9</b> YEAR <b>49</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>34</b> YRS.   |  | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                    |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>402 N. Eutaw St.</b> |  |  |  | 17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                      |  |   |  |  |  |  |  |  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b></b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>918 Veronica Avenue 21225</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Melvin</b> MIDDLE <b>Lee</b> LAST <b>Sheppard, Sr.</b>   |  |                      |  |   |  |  |  |  |  |  |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nettie</b> MIDDLE <b>Mae</b> LAST <b>Myrick</b>   |  |                      |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b></b>  |  |  |  | 17. INFORMANT ADDRESS <b>Euther Steele 611 Bridgeview Road</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9650 IMMEDIATE CAUSE (a) Gunshot wound to chest (handgun)</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b></b><br>(c) <b></b>  |  |                      |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |                      |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR <b>6:40</b> MONTH <b>2</b> DAY <b>8</b> YEAR <b>84</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject was shot.</b>   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>building</b>   |  |  |  | 21f. LOCATION<br>STREET <b>402 N. Eutaw St., Balto.</b> CITY OR TOWN <b>Balto.</b> COUNTY <b></b> STATE <b>Md.</b>                                       |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE    |  |                      |  | TITLE (SPECIFY) <b>Assistant</b> M.D. <b>Assistant</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>2-9-84</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |  | 23b. DATE <b>2/13/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Zion Cemetery</b>                                |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Lansdowne, Md.</b> COUNTY <b></b> STATE <b></b>                         |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE    |  |  |  |

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FOR  
1 - STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 4 4 2 3  
REG. NO.

|   |  |   |                                   |  |  |   |  |  |  |                                   |  |
|---|--|---|-----------------------------------|--|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rita</b>   |  |   | FIRST MIDDLE LAST <b>Sheppard</b> |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 - 10 - 84</b>   |  |  |  | 2b. HOUR <b>2:50 PM</b>           |  |
| 3 SEX <b>FEMALE</b>   |  | 4 RACE <b>Caucasian</b>   |                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>85</b> YRS   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  | IF UNDER 24 HRS<br>HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                  |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b> |                                   |  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |                                   |  |  | 21201   |  |  |  |                                   |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY   |                                   | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>607 Pennsylvania Avenue</b>    |  |                                   |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                               |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  |  | 16b. SOCIAL SECURITY NO.                             |  |  |
| 17. INFORMANT  |  |  | ADDRESS <b>Greater Deft. Nursing Home 607 Read A</b> |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>D380</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>septicemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Streptococcal Toxicosis Bacteremia</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

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|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a*<br><b>Fracture of hip: Atherosclerotic Cardiovascular Disease</b> |  |  |  |
|--|--|--|--|

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/><br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>8:30 12 11 83</b>                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>FALL - ACCIDENT</b>  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Nursing home</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>607 Penns YL Wndmre Balto, Md.</b>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 11</b> 19 <b>83</b> to <b>Feb 10</b> 19 <b>84</b> that (I) (we) lost<br>saw the deceased alive on <b>Feb 10</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Franklin J. Addison</b>   |  | DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | DATE SIGNED <b>2-10-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Franklin J. Addison</b>  |  | 22e. ADDRESS<br><b>2600 Liberty Hqts Balto, Md</b>  |  |   |  |  |  |

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 23a. BURIAL CREMATION, REMOVAL   |  | 23b. DATE <b>2/19/84</b>                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>W. North A</b>     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Charles</b> ADDRESS <b>1712 W. North A</b> |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |                   |   |  |   |  |  |  |  |  |
|--|--|---|-------------------|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST |   |  | 7a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 7b. HOUR                                     |  |
| LESTER SHERMAN   |  |   |                   |   |  | 02 25 84  |  |  |  | 8:05 PM                                      |  |
| 3. SEX   |  | 4. RACE   |                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| MALE   |  | WHITE   |                   | 10 23 04  |  | 79 YRS.   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |  |  |  |  |  |
| VIRGINIA   |  | U.S.A.  |                   |   |  | BALTIMORE CITY MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| BALTIMORE  |  | ST. AGNES HOSPITAL E.R.   |                   |   |  | TRUCK DRIVER  |  | BLDG. MATERIALS  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |                   |   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |                   | 13c. CITY OR TOWN   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 1702 HARMAN AVENUE, 21230  |  |  |  |
| MARYLAND   |  | ---   |                   | BALTIMORE   |  |   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |  |  |
| BENJAMIN F. SHERMAN  |  |   |                   | AMANDA SHIPE  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |                   | 17. INFORMANT   |  | ADDRESS   |  |  |  |  |  |
| NO   |  | 216-01-1610   |                   | WAYNE L. SHERMAN  |  | 1702 HARMAN AVENUE, 21230   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Empty Sema</u><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>pneumonia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |                   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |   |                   |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF INJURY, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
|  |  |   |                   | 324 19 84, to 325 19 84   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> 19 <u>84</u> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |                   |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Kuang-yen Huang</u>   |  |   |                   | DEGREE<br><u>MD</u>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>3/29/84</u>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KUANZ YEN HUANG, M.D.   |  |   |                   | 22e. ADDRESS<br>517 SCOTT STREET  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |
| BURIAL   |  | 02-29-84  |                   | LOUDON PARK   |  | BALTIMORE CITY MARYLAND   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |                   | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| HUBBARD FUNERAL HOME, INC.   |  |   |                   | 4107 WILKENS AVE.   |  | FEB 29 1984   |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ERNEST MITCHELL SHERRILL</b>   |  |   |  | 2b. HOUR <b>4<sup>00</sup> M</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>01 27 19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENG. FOREMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOV'T</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>353 WHITFIELD ROAD, 21228</b>  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ERNEST SHUFORD SHERRILL</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNIELOU SHERRILL</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |  | 17. INFORMANT ADDRESS<br><b>VIOLET E. SHERRILL 353 WHITFIELD ROAD</b>   |  | 21228   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Chronic Obstructive Pulmonary Disease</b>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-14</b> , 19 <b>84</b> , to <b>2-22</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-22</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Ambachew Woreta</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>2/22/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AMBACHEW WORETA</b>  |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL<br/>900 CATON AVE BALTIMORE MD 21229</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>02-24-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

04926

1- FOR  
STATE  
REGISTRAR

|  |  |                  |   |  |  |   |  |                                   |   |                                   |  |  |  |  |
|--|--|------------------|---|--|--|---|--|-----------------------------------|---|-----------------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SIDNEY NMN SHERWOOD |  |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 9 84   |  |  | 2b. HOUR<br>6:17P M   |  |                                   |   |                                   |  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 10, 1901 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |   | 7b. IF UNDER 24 HRS<br>HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland      |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |                                   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                     |  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Diplomatic Corps  |  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Foreign Services       |                                   |  |  |  |  |
| 13a. STATE<br>Maryland                                     |  |                  | 13b. COUNTY<br>Baltimore, Cockeysville  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                   | 13d. STREET ADDRESS<br>13801 York Road, #21030              |                                   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sidney Sherwood  |  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Abigail Beattie   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |                                   | 16b. SOCIAL SECURITY NO.<br>577-60-4970                     |                                   |  | 17. INFORMANT<br>ADDRESS<br>Cockeysville, 21030<br>Mrs. Oliba Sherwood, 13801 York Rd. Md. |  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>COR PULMONALE</u><br><u>4960</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Chronic Obstructive lung disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                     |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Failure</u>   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>1/23</u> 19 <u>84</u> to <u>2/9</u> 19 <u>84</u> , that (I) <u>we</u> <input checked="" type="checkbox"/> saw the deceased alive on <u>2/9</u> 19 <u>84</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <input checked="" type="checkbox"/> (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Meenakshi Merchant MD</u>  |  |  |  | 22c. DATE SIGNED<br><u>2/9/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MEENAKSHI MERCHANT</u>  |  |  |  | 22e. ADDRESS<br><u>SINAI HOSP</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Cremation</u>  |  | 23b. DATE<br><u>Feb 11, 1984</u>                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Westview Mem. Pk.</u>                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Catonsville, Balto. Co., Md.</u>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Martin D. Lawson</u> ADDRESS <u>10 W. Padonia Rd. Timonium</u>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>FEB 14 1984</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |  |

BP

3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04427

REG. NO.

|   |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM T. SHOLLY  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB. 24 1984                    |   |  | 2b. HOUR<br>M  |   |  |  |
| 3. SEX<br>M   |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8/12/34   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>PA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CITY HOSP. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>STEEL   |  |
| 13a. STATE<br>MD.   |  |  | 13b. COUNTY<br>BALTO   |   | 13c. CITY OR TOWN<br>EASTMONT                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>THOMAS J. SHOLLY  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH G. LOUDEN       |   |  | 13e. STREET ADDRESS<br>8052 LANSDALE RD  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>KOREA 216-32-2019   |  | 17. INFORMANT<br>BETTY SHOLLY   |  |  | 17. ADDRESS<br>ABOVE  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute C.H.F.</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <u>ASCVD</u><br>(c) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u>   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>Present</u> , 19____, that (I) (we) last saw the deceased alive on <u>2/23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>N. Carmona</i>   |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/27/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Nestor M. Carmona, M.D.  |  |  | 22e. ADDRESS<br>6012 Harford Road 21214                                |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>2/28/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.G. CONNELLY   |  |  | ADDRESS<br>300 MACE  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 1 1984  |   | 25b. REGISTRAR'S SIGNATURE<br><i>J. G. Connelly</i>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

10/11/19

WILLIAM T. SHAW

PA

W

CHARTER CITY

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8025 LANSBURY RD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04428

|  |  |  |   |
|--|--|--|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |   |
| FIRST MIDDLE LAST<br>William (Seibert)   |  | MONTH DAY YEAR HOUR<br>2-2-1984 10:25 P.M.   |   |
| 3 SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |
| MALE   | BLACK  | MONTH DAY YEAR<br>5 4 91   | 92  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| UNKNOWN  | U.S.A.   |  | BALTIMORE CITY MD.  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| City BALTO   | LUTHERAN Hospital  |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 13a. COUNTY  | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?  |
| 13a. STATE<br>Maryland   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   | 17. INFORMANT ADDRESS  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>214-105945   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4960<br>DUE TO, OR AS A CONSEQUENCE OF (b) End stage chronic obstructive pulmonary disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory Failure                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)  |  |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
|  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-25-1984, to 2-2-1984, that (I) (we) lost<br>saw the deceased alive on 2-2-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>A. Vento, M.D.   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>2-2-1984   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS   |  |   |
| A. Vento   | Lutheran Hospital, Baltimore, MD.  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |
| BURIAL   | 2/9/84   | Mount Zion Cemetery  | Lansdowne, Md.  |
| 24. FUNERAL DIRECTOR<br>NAME   | 25a. DATE REC'D. BY REGISTRAR  | 25b. REGISTRAR'S SIGNATURE   |   |
| Wm C March F/H Inc. 1101 E North Avenue  | FEB 7 1984   | John J. Ganiel   |   |

BP

1700-1800

1800-1900

1900-1950

1950-2000

2000-2050

2050-2100

2100-2150

2150-2200

2200-2250

2250-2300

2300-2350

2350-2400

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3900-3950

3950-4000

4000-4050

4050-4100

4100-4150

4150-4200

4200-4250

4250-4300

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4350-4400

4400-4450

4450-4500

4500-4550

4550-4600

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The funeral director should be furnished with a copy of this certificate and page 4. The funeral director should be furnished with a copy of this certificate and page 4. The funeral director should be furnished with a copy of this certificate and page 4.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified and a medical examination must be performed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |                                   |
|---|--|---|--|---|--|---|--|---|-----------------------------------|
| REG. NO.  |  |   |  |   |  |   |  |   |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>RICHARD S. SIDES</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 2, 1984</b>                                  |   | 2b. HOUR A M<br><b>1:10 M</b>  |   |                                   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasin</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 19 19 09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>64</b>                                   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                   |  |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Admin. Asst</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>D &amp; E Tele.</b>   |                                   |
| 13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Pa.</b>  |  |   |  |   | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13c. STREET ADDRESS<br><b>309 Edgehill Drive 17504</b>   |   |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jacob S. Sides</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Helen B. Groover</b>                        |   |  |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW 11</b>  |  | 17. INFORMANT<br><b>Martha S. Sides</b>   |  | ADDRESS<br><b>309 Edgehill Dr. Akron, Pennsylvania</b>                              |  |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |   |  |   |  |   |                                   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>5761</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>MULTIPLE ORGAN FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |   |  |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>SCLEROSING CHOLANGITIS / HEPATIC FAILURE</b>  |  |   |  |   |  |   |  |   |                                   |
| 19a. DATE OF OPERATION<br><b>12/20/83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>SCLEROSING CHOLANGITIS</b>   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |                                   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> , 19 <b>83</b> , to <b>2/2</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/1</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |                                   |
| 22b. SIGNATURE<br><b>Hoellerich</b>   |  |   |  |   | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/2/84</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VL HOELLERICH</b>   |  |   |  |   | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL<br/>600 WAKE ST. BALTO. 21205, MD.</b>         |   |  |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-4-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion U.M. Cem</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Akron Pa.</b>                         |  |   |                                   |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>MacNabb Funeral Home Catonsville, Md.</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |                                   |



FILED

POST OFFICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, please see item 19.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                                   |   |  |  |  |  |                           | REG. NO. 04430  |  |  |
|--|--|--|-----------------------------------|---|--|--|--|--|---------------------------|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |                                   |   |  |  |  |  |                           |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARGUERITE EBERT SIEBERT</b>  |  |  |                                   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 25, 1984</b>         |  |  |  | 2b. HOUR<br><b>8 A.M.</b> |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |                                   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 16, 1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>93</b> YRS.                                |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.  |                           |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |  |                           |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>500 W. University Parkway</b> |                                   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                           |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |                                   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>500 W. University Parkway 21210</b>   |                           |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Oscar H. Ebert</b>   |  |  |                                   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sarah E. Arnold</b> |  |  |  |                           |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-46-3646</b>   |                                   | 17. INFORMANT ADDRESS<br><b>Miss Sara L. Siebert Same</b>   |  |  |  |  |                           |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>15 years</b> |  |  |                                   |   |  |  |  |  |                           |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |                                   |   |  |  |  |  |                           |   |  |  |
| 19a. DATE OF OPERATION   |  |  |                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |                                   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |  |                           |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |  |                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |                           |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 20</b> , 19 <b>66</b> , to <b>Feb 25</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Feb 23</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I) (did not) view the body after death.              |  |  |                                   |   |  |  |  |  |                           |   |  |  |
| 22b. SIGNATURE<br><b>L. Myrton Gaines</b>  |  |  |                                   | DEGREE<br><b>M.D.</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                           | 22c. DATE SIGNED<br><b>2/27/84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. Myrton Gaines, M.D.</b>   |  |  |                                   | 22e. ADDRESS<br><b>7800 York Rd. Towson, Md. 21204</b>  |  |  |  |  |                           |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Feb. 27, 1984</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>             |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Pikesville, Balto. Co., Md.</b>  |                           |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>  |  |  |                                   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 28 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |                           |   |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04431

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>REBECCA SIEGEL   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB. 6 1984  |   | 2b. HOUR<br>2:50 P.M.                     |
| 3. SEX<br>FEMALE   | 4. RACE<br>CAUCASIAN   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 29 1903  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LEVINVALE HEBREW GERIATRIC HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK                       | 12b. KIND OF BUSINESS OR INDUSTRY<br>US GOV'T.                                |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND |  | 13b. COUNTY<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3820 FORDS LANE #204 21215                             |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ISAAC SIEGEL   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SOPHIA GREENHOUSE  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                 |  | 16b. SOCIAL SECURITY NO.<br>213-09-9655A  |   | 17. INFORMANT<br>MISS ANNA SIEGEL APT. 204<br>3800 FORDS LA. BALTO., MD 21215 |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONIA<br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (this hospital) attended the deceased from 2/6 1984, to 2/6 1984, that (we) last saw the deceased alive on 2/6 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br>Estrelita O. Ku   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>2/6/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ESTRELITA O. KU  |  | 22e. ADDRESS<br>LEVINVALE HEBREW GERIATRIC CENTER + Hospital           |  |   |  |

|  |                          |   |  |
|--|--------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL | 23b. DATE<br>FEB. 7 1984 | 23c. NAME OF CEMETERY OR CREMATORY<br>AHAVAS SHALOM | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD |
|--|--------------------------|---|--|

|  |  |  |
|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215 | 25a. DATE REC'D. BY REGISTRAR<br>FEB 10 1984 | 25b. REGISTRAR'S SIGNATURE<br>John J. Canfield |
|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 4 4 3 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |  |  |   |  |
|--|--|--|---|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>ERNEST B. SIEGMAN</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/26/84</b>                  |  |  | 2b HOUR<br><b>5:55<sup>P</sup></b>   |  |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 2, 1911</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inspector-Glenn</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>L. Martin Co</b>   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b COUNTY<br><b>MD</b>  |   | 13c CITY OR TOWN<br><b>Balto.</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS / ZIP CODE<br><b>404 Rossiter Ave. 21212</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin F. Siegman</b>  |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Auld</b>   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213 01 6879</b>   |   | 17 INFORMANT<br><b>Mrs. Marjorie M. Siegman,</b>   |  | ADDRESS<br><b>Same</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>probable pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rt adenocarcinoma squamous cell carcinoma lung</b> |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>February 22, 19 84</b> , to <b>February 26, 19 84</b> , that (I) (we) lost saw the deceased alive on <b>February 26, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |  |  |   |  |
| 22b SIGNATURE<br><b>Victoria A. Vanik MD</b>   |  |  | DEGREE  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>2/26/84</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VICTORIA A. VANIK</b>   |  |  | 22e ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                         |  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b DATE<br><b>2/29/84</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Ressurrection Acres</b>              |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co., MD</b> |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Road Balto., MD 21212</b>   |  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>FEB 27 1984</b>                           |  |  |   |  |
| 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>   |  |  |   |  |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



U.S. DEPARTMENT OF THE ARMY

100-100000

WASHINGTON, D.C.

USA

UNION MEMORIAL HOSPITAL

WASHINGTON

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WASHINGTON, D.C.

UNION MEMORIAL HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to make an autopsy.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.                   |  |  |
|--|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mahmel Silberg</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>21</b> YEAR <b>1984</b> |   | 2b. HOUR<br><b>6:35 AM</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>06</b> YEAR <b>05</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital of Baltimore</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TAILOR</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>XXXXXXX</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                            | 13e. STREET ADDRESS<br><b>APT. 2C #21215<br/>3605 Labyrinth Rd.</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>SAMUEL</b> MIDDLE <b>SILBERG</b> LAST <b>SILBERG</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>HATTIE</b> MIDDLE <b>BANK</b> LAST <b>BANK</b>   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>577-48-3719</b>  |  | 17. INFORMANT<br><b>APT. 2C ADDRESS 3605 LABYRINTH RD.<br/>Goldie Drucker BALTO., MD 21215</b>  |                            |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1539 Cardio-pulmonary arrest, possible MI</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pleural effusion, Pneumothorax</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Colon carcinoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>17 hours</b><br><b>7 days</b><br><b>9 months</b>                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/13</b> , 19 <b>84</b> , to <b>2/21</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/21</b> , 19 <b>84</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>Chun-Kang Huang</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                            | 22c. DATE SIGNED<br><b>2/21/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Chun-Kang Huang</b>  |  |   |  | 22e. ADDRESS<br><b>Sinai Hospital of Baltimore</b>  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>FEB. 22, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH</b>   |                            | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MARYLAND</b>                                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1984</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

BP



RECEIVED  
JAN 1 1891  
NEW YORK

NOV 10 1890

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

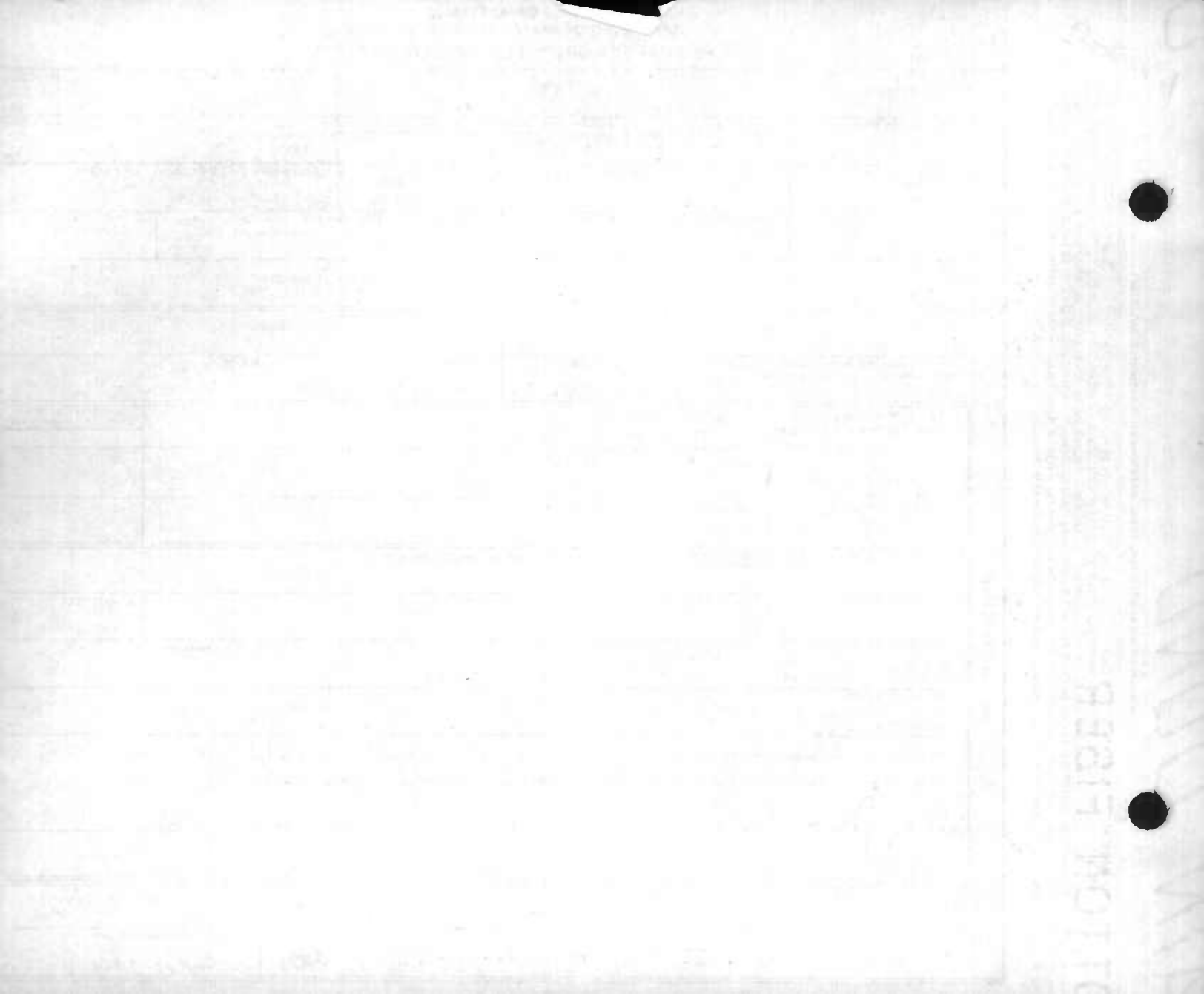
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(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |         |  |  |  |                   |  |  |  |                  |  |   |  |          |  |
|--|--|---------|--|--|--|-------------------|--|--|--|------------------|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  | FIRST MIDDLE LAST  |  |                   |  | 2a. DATE KNOWN OF DEATH  |  |                  |  | 2b. HOUR  |  |          |  |
| FREDERICK B. SILLS   |  |         |  |  |  |                   |  | 2. DATE KNOWN OF DEATH   |  |                  |  | 2b. HOUR  |  |          |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR |  |
| Male   |  | Black   |  | 1 3 23   |  | 61 YRS.           |  | MONTHS   |  | DAYS             |  | 2. 4 1984   |  | 8:25 AM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |          |  |
| N. Carolina  |  |         |  | U.S.A.   |  |                   |  |  |  |                  |  | Baltimore City MD.  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |  |
| Baltimore  |  |         |  | Deaton Medical Center  |  |                   |  |  |  |                  |  |   |  |          |  |
| 13a. STATE   |  |         |  | 13b. COUNTY  |  |                   |  | 13c. CITY OR TOWN  |  |                  |  | 13d. INSIDE CITY LIMITS?  |  |          |  |
| Maryland   |  |         |  |  |  |                   |  | Baltimore  |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME   |  |                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |                  |  | 16b. SOCIAL SECURITY NO.  |  |          |  |
| John   |  |         |  | Agnes  |  |                   |  | UNKNOWN  |  |                  |  | 245-20-4279   |  |          |  |
| 17. INFORMANT  |  |         |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                   |  | 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |          |  |
| Gertrude Daniels   |  |         |  | PART I DEATH WAS CAUSED BY:  |  |                   |  |  |  |                  |  |   |  |          |  |
| 1306 McCulloh St.  |  |         |  | IMMEDIATE CAUSE (a) Fracture of neck with complications  |  |                   |  |  |  |                  |  |   |  |          |  |
|  |  |         |  | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                   |  |  |  |                  |  |   |  |          |  |
|  |  |         |  | (b) _____  |  |                   |  |  |  |                  |  |   |  |          |  |
|  |  |         |  | (c) _____  |  |                   |  |  |  |                  |  |   |  |          |  |
|  |  |         |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                   |  |  |  |                  |  |   |  |          |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                   |  | 20. AUTOPSY?   |  |                  |  |   |  |          |  |
|  |  |         |  |  |  |                   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                  |  |   |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  |         |  | 21b. TIME OF INJURY  |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                  |  |   |  |          |  |
|  |  |         |  | ? P.M. 8-13-1983   |  |                   |  | Unknown.   |  |                  |  |   |  |          |  |
| 21d. INJURY OCCURRED   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                   |  | 21f. LOCATION  |  |                  |  |   |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |         |  | street   |  |                   |  | 200 S. Dallas Ct., Balto.  |  |                  |  | Md.   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on  |  |         |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |                   |  |  |  |                  |  |   |  |          |  |
| death resulted from:   |  |         |  | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |                   |  |  |  |                  |  |   |  |          |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)  |  |                   |  | DATE SIGNED  |  |                  |  |   |  |          |  |
| Ann M. Dixon, M.D.   |  |         |  | M.D. Assistant MEDICAL EXAMINER  |  |                   |  | 2-5-84   |  |                  |  |   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS  |  |                   |  | 111 Penn St., Balto., Md. 21201  |  |                  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |         |  | 23b. DATE  |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                  |  | 23d. LOCATION   |  |          |  |
| BURIAL   |  |         |  | 2/8/84   |  |                   |  | Mount Zion Cemetery  |  |                  |  | Lansdowne, Md.  |  |          |  |
| 24. FUNERAL DIRECTOR   |  |         |  | 25a. DATE REC'D. BY REGISTRAR  |  |                   |  | 25b. REGISTRAR'S SIGNATURE   |  |                  |  |   |  |          |  |
| Wm C March F/H Inc.  |  |         |  | FEB 7 1984   |  |                   |  |  |  |                  |  |   |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | REG. NO.   |  |
|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HOWARD W. SIMMONS</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>02-05-84</b>              |   | 2b. HOUR<br><b>3:45 PM</b>                         |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 27 28</b>  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.  |  |  | 10. CITY OR TOWN OF DEATH<br><b>Balto</b>                        |   |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b>  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Amstar</b> |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Aaron Simmons</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie Ritter</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Emily Simmons</b>   |  |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>  |  | 18. IF YES, GIVE WAR OR DATES  |  | 19. ADDRESS<br><b>5506 Robinwood Ave.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>15 years</b><br>Approximate interval between onset and death: <b>35 minutes</b> |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |
| 22b. SIGNATURE<br><b>Mark Adelman</b> MD  |  | 22c. DATE SIGNED<br><b>2/5/84</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK ADELMAN MD</b>   |  |  |
| 22e. ADDRESS<br><b>SINAI HOSPITAL</b>   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>2/9/84 Burial</b>  |  |   |  |  |
| 23b. DATE<br><b>2/9/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet. Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Reisterstown, Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leroy O. Dyett &amp; Son F. H. Inc</b>  |  | 24b. ADDRESS<br><b>4600 Liberty High Ave</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1984</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>   |  |  |  |   |  |  |

BP \_\_\_\_\_

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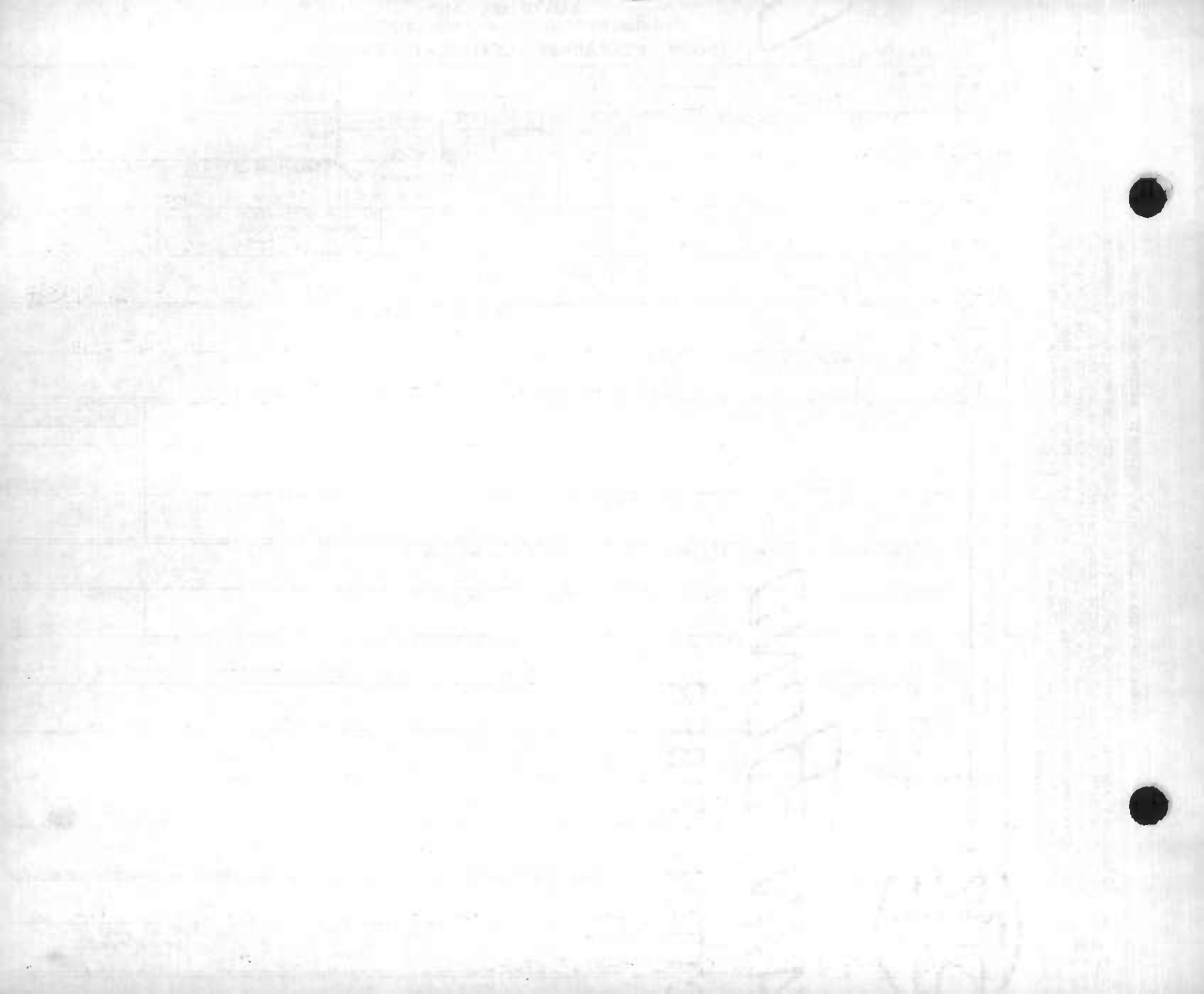
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |  |   |  |  |  | REG. NO.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|-------------------------|--|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROBERT J. SIMMS</b>  |                         |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>2 9 1984</b>                        |  | 2b. HOUR<br>a M<br><b>3:09 a M</b>                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 26 1957</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>26</b> | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN<br><b>26</b>   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2 9 1984</b>                       |  | 2d. HOUR<br>a M<br><b>3:09 a M</b>                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br><b>University Hospital (STU)</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECURITY G.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sec. Co.</b> |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |                         |  |  |   |  |   |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13c. CITY OR TOWN<br><b>CARNEY</b>   |                         |  |  |   |  |   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John K. Simms</b>   |                         |  |  |   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Joan B. SPERL</b>                           |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         |  |  |   |  |   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215 54 3212</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT<br><b>FAMILY RECORDS</b>   |                         |  |  |   |  |   |  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>8152 Thoracic trauma</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                         |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |                         |  |  |   |  |   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>2:16xx 2-9- 19 84</b>  |                         |  |  |   |  |   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2:16xx 2-9- 19 84</b>                     |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Operator in motorcycle/fixed object impact.</b> |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         |  |  |   |  |   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>                      |  |  |  |  |  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Fairmount Ave. &amp; Glenview Ave., Balto. Md.</b>                          |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Ann M. Dixon</b>  |                         |  |  |   |  |   |  |  |  | TITLE (SPECIFY)<br><b>Assistant</b> M.D. MEDICAL EXAMINER                                       |  |  |  |  |  |  |  |  |  | DATE SIGNED<br><b>2-9-84</b>  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |                         |  |  |   |  |   |  |  |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |                         |  |  |   |  |   |  |  |  | 23b. DATE<br><b>FEB 13, 1984</b>  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>   |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ESSEX BALTIMORE MARYLAND</b>  |                         |  |  |   |  |   |  |  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1984</b>   |  |  |  |  |  |  |  |  |  | 23f. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Pandell</b>  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES HARFORD ROAD</b>   |                         |  |  |   |  |   |  |  |  | 24b. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1984</b>   |  |  |  |  |  |  |  |  |  | 24c. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Pandell</b>  |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION



Item 130

per ph. 2/10/84 kg

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04437

1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elise S. Clegg Simpson</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 2 1984</b> |   |  | 2b. HOUR<br><b>M</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 11 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b> NY   |  | 13b. CITY OR TOWN<br><b>Baltimore</b> NY  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>1539 Lexington Ave. New York, N. Y. 10029</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Thomas Glegg</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Sowell</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>108-26-7211</b>  |  | 17. INFORMANT<br><b>Robert Simpson</b>  |  | 17. ADDRESS<br><b>1539 Lexington Ave. Apt. 13A New York, N. Y. 10029</b>           |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe, Accepted Hypertension with Acute pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br><b>4019</b> |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs</b><br><b>20 min</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b>Congestive Heart Failure, recurrent</b>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/30</b> , 19 <b>83</b> , to <b>2/2</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/28</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>E. Saunders</b>   |  | DEGREE  |  | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>2/6/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elijah Saunders, M. D.</b>   |  | 22e. ADDRESS<br><b>2 Hamill Rd. Balto., Md. 21210</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/6/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Nutter &amp; Sons</b> ADDRESS <b>2501 Gwynns Falls Pkwy.</b>   |  |   |  | DATE REC'D. BY REGISTRAR<br><b>FEB 7 1984</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                 |  |  |  |
| Funeral Home Inc. Baltimore, Md. 21216   |  |   |  |   |  |  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-6999.

100-1



|        |      |        |       |     |                              |                       |
|--------|------|--------|-------|-----|------------------------------|-----------------------|
| 100-1  | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |
| 100-2  | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |
| 100-3  | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |
| 100-4  | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |
| 100-5  | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |
| 100-6  | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |
| 100-7  | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |
| 100-8  | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |
| 100-9  | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |
| 100-10 | John | Thomas | Clegg | Ann | 1234 Lexington Ave. Apt. 13A | New York, N. Y. 10023 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar, death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04438

REG. NO.

|   |  |  |  |   |  |  |   |   |  |
|---|--|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAXINE Mary SIMPSON</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>02 08 84</b>   |   |  | 2b. HOUR <b>7 45</b> <sup>PM</sup>   |   |   |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>11 28 21</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cumberland, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY OF MARYLAND</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse - Retired</b>                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Hos</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>DE</b> COUNTY <b>Sussex</b>   |  |  | 13b. CITY OR TOWN <b>REHOBETH</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>32 CARRIAGE LANE 19971</b> |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>John William Dahl</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Louise Wade</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>--</b> 16b. SOCIAL SECURITY NO. <b>215-M-6365</b> |   |   |  |
| 17. INFORMANT <b>Mr. Marion B. Simpson, Rehoboth, Del. 19971</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Edema and Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Subarachnoid Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4301</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>   |  |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION <b>2/7/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Aneurysm of Right Middle Cerebral Art.</b>                                       |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/5</b> 19 <b>84</b> to <b>2/8</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/5</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |   |  |
| 22b. SIGNATURE <b>J. Parkerson MD</b>   |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |   | 22c. DATE SIGNED <b>2/8/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J PARKERSON MD</b>   |  |  |  | 22e. ADDRESS <b>UNIVERSITY HOSPITAL</b>   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2-13-1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Belair Mem. Gardens</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford Md.</b>   |   |   |  |
| 24. FUNERAL DIRECTOR NAME <b>E.F. Lassahn</b> ADDRESS <b>11750 Belair Rd. Kingsville, Md. 21087</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>B 14 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson Randall</b>   |   |   |  |

2119 relol.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04439

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BABY BOY (WANDA) SINGLETARY</b>                        |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 22 84</b> |   |  | 2b. HOUR<br><b>1130 P.M.</b>  |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>BL</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 22 84</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>000/365</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>1 00</b>         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>MD</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3504 LUCILLE AVE. 21215</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SINGLETARY</b>                                      |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>WANDA</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>---</b>  |  | 17. INFORMANT<br>ADDRESS  |  |  |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **BIRTH ASPHYXIA****7650**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **EXTREME PREMATURITY (24 WEEKS)**

DUE TO, OR AS A CONSEQUENCE OF

(c) **---**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**7 hr.**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>---</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/22</b> , 19 <b>84</b> , to <b>2/22</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/22</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not see the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Joachim M.B. Pinheiro, MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/23/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOAQUIM M.B. PINHEIRO</b>  |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL - PEDIATRICS</b>   |  |  |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>CREMATION</b>            |  | 23b. DATE<br><b>2-24-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SINAI Hospital</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SINAI Hospital</b> ADDRESS<br><b>BALTO, MD</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1984</b>          |  |   |  |
|   |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for autopsy.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04440

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIAN SKIPPS</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 26, 1984</b> |   |  | 2b. HOUR<br><b>12:58 P.M.</b>   |  |
| 3. SEX<br><b>Female</b>                                      |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 23, 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Long Green Nursing Center</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b> |  |
|  |  |   |   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>                                  |  |

|   |                                 |   |   |
|---|---------------------------------|---|---|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                       |                                 |   |   |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b> | 13c. CITY OR TOWN<br><b>Baltimore</b>                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Vincent Skipps</b>   |                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth</b> |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |                                 | 16b. SOCIAL SECURITY NO.<br><b>218-01-3666</b>                    |   |
| 17. INFORMANT<br><b>Mrs. Virginia Mallonee</b>  |                                 | ADDRESS<br><b>3018 Louise Ave. 21214</b>                          |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b><br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>yes</b> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.

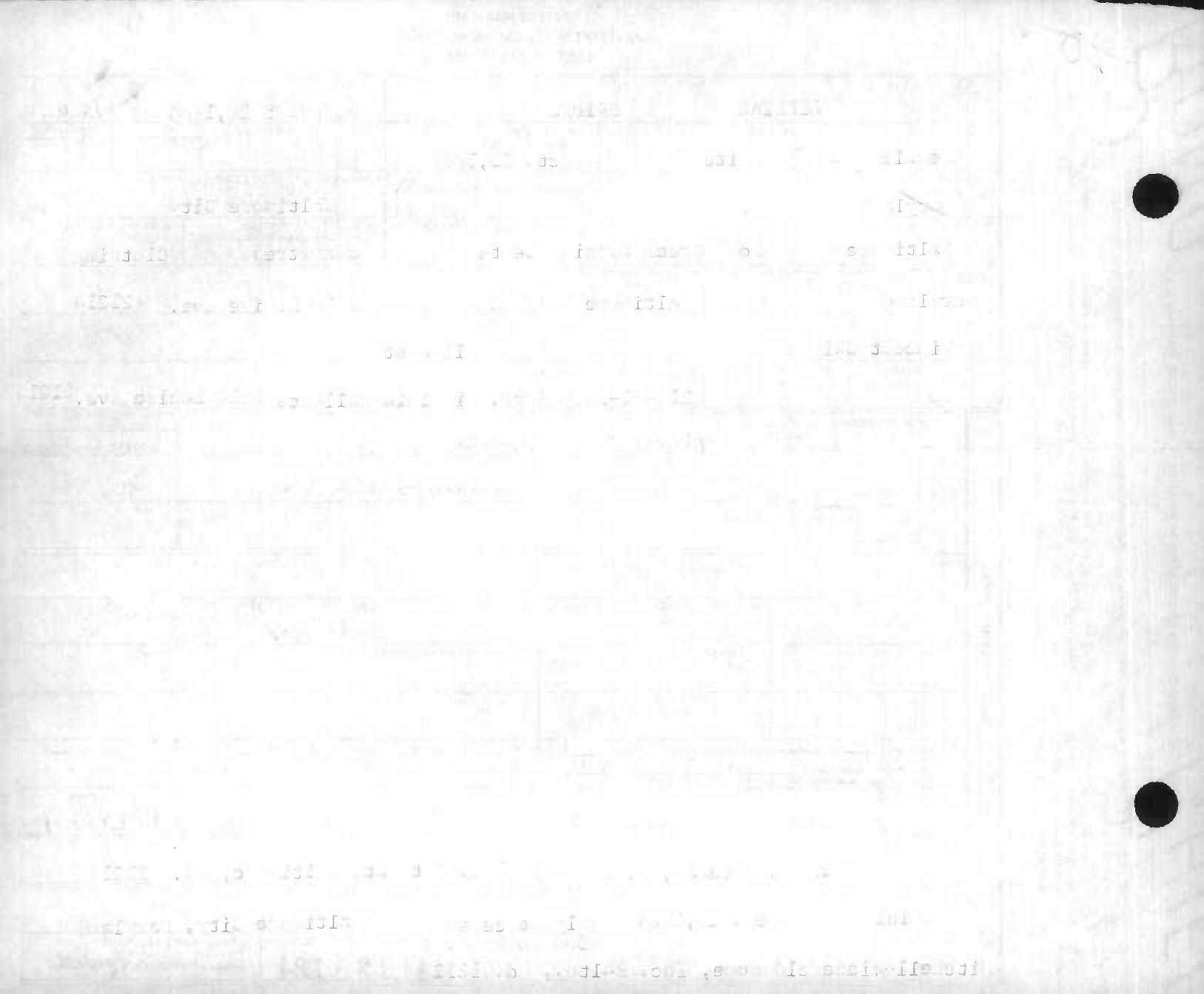
|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <u>Donald T. Weglein</u> attended the deceased from <u>2/27</u> , 19 <u>84</u> , to <u>2/27</u> , 19 <u>84</u> , that (I) <u>we</u> last saw the deceased alive on <u>2/27</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Donald T. Weglein M.D.</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/28/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE)<br><b>Donald T. Weglein, M.D.</b>  |  | 22e. ADDRESS<br><b>222 W. Cold Spring Baltimore, Md. 21210</b>         |  |  |  |  |  |

|  |  |                                   |  |   |  |   |  |
|--|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                          |  | 23b. DATE<br><b>Feb. 29, 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 28 1984</b>         |  |   |  |
|  |  |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

Item #5, 6 2/8/84 mtb F#588

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |   |  |  |  |
|---|---|--|---|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>LEONARD W. SKOURUNSKI</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02-04-84</b>          |   |  | 2b. HOUR<br>6 <sup>15</sup> <sub>A</sub> M   |  |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>CAUCASIAN</b>                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02-22-29</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MS.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen. Hosp.</b>             |   | 12a USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Food Warehouse Co.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chemical</b>   |  |
| 13a. STATE<br><b>MS.</b>  |   | 13b. COUNTY<br><b>MS.</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e STREET ADDRESS / ZIP CODE<br><b>1500 OLNEY ST 21236</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HIPOLITE - SKOURUNSKI</b>  |   |  | 15. MOTHER'S MAIDEN NAME<br>LAST<br><b>Sophie Prsybystawski</b> |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Aug. 1948-May 1953 220-22-1565</b>  |   | 17 INFORMANT<br><b>JOYCE COUNCIL</b>  |  | ADDRESS<br><b>308 11th Ave.</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>CARDIAC Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe Acute Antero lateral MI</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Cardiogenic Shock - Previous MI</b> |   |  |   |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED<br>(NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 21e. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21f. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21h. DATE SIGNED<br><b>02-04-84</b>  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB. 3</b> 19 <b>84</b> to <b>FEB. 4</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |  |   | 22b. SIGNATURE<br><b>CO. Rogers, Vick</b>   |  | 22c. DATE SIGNED<br><b>02-04-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PROFESSOR DR. R. C. FINK</b>  |   |  |   | 22e. ADDRESS<br><b>300 S. HANOVER ST. BALTO. MD. 21230</b>  |  | 22f. DATE REC'D. BY REGISTRAR<br><b>FEB 6 1984</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>27-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie (A.A.) Md.</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Raymond C. Fink</b>   |   |  |   | 24b. ADDRESS<br><b>Glen Burnie, Md</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 6 1984</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>R. C. Fink</b>   |   |  |   | 25c. REGISTRAR'S SIGNATURE<br><b>R. C. Fink</b>   |  |  |  |

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



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U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Edward Skudna</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>February 11, 1984</i>        |   |   | 2b. HOUR<br>M<br><i>AM</i>   |   |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>May 25 1918</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS MIN.<br><i>65</i>  |   | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Penn</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>South Balt. Gen. Hospital</i> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Own</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Bar</i>  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>---</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><i>1505 Sycamore Street</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Harry Skudna</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Bessie Chechlowa</i>  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>064-01-9475</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Mary Skudna (wife) same as 13</i>  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Pulmonary Embolism</i><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>CAD w/ Artery Thromb</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>COPD (DOA ON SRGH ETC.)</i> |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>---</i>   |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/31/84</i> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If aerrand did not see the body after death.)   |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Carlos N. Patalinghug</i>   |  |   | 22e. ADDRESS<br><i>403 E. Patapsco Ave Balto., Md. 21225</i>           |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>Feb. 4, 1984</i>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Most Holy Redeemer</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City Md.</i> |  |  |
| 24. FUNERAL DIRECTOR<br><i>McCutty Funeral Home</i>   |  |   | 4200 Pennington Ave<br>Balt. Md. 21226                                 |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 3 1984</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



1949

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04443

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| FOR<br>1- STATE<br>REGISTRAR   |                                     | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARIE C. SLACUM   |                                     | 2a. DATE OF DEATH MONTH DAY YEAR<br>02/23/84  |  |
| 2b. HOUR<br>2:00P<br>M   |                                     |   |  |
| 3. SEX<br>Female   | 4. RACE<br>White                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 5, 1896  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS  |                                     | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |                                     | 10. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital  |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |                                     |   |  |
| 13a. STATE<br>MD   |                                     | 13b. COUNTY<br>Baltimore  |  |
| 13c. CITY OR TOWN<br>Baltimore   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |                                     | 16b. SOCIAL SECURITY NO.<br>212 03 0992   |  |
| 17. INFORMANT<br>ADDRESS<br>Mrs. Anna M. Balbier, Balto., MD   |                                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>hypercalcemia</u><br>1991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>metastatic transitional cell cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |                                     |   |  |
| 19a. DATE OF OPERATION   |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                     |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                     |   |  |
| 22a. I certify that (he) (this hospital) attended the deceased from 1/20, 19 84, to 2/23, 19 84, that (I) (we) last saw the deceased alive on 2/23/84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.  |                                     |   |  |
| 22b. SIGNATURE<br>S M Hollander  |                                     | 22c. DATE SIGNED<br>2/23/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S M Hollander   |                                     | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL BALTO MD   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                                     | 23b. DATE<br>2/27/84  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge  |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |                                     | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1984  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Yonkers, N.Y. 10550  
J. Edgar Hoover  
U.S. Department of Justice  
Washington, D.C. 20535

Enclosure

MD



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARLENE D SLEDZIANOWSKI</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 14 84</b>   |   |  | 2b. HOUR<br>4.20 P.M.  |  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b>                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 02 37</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND</b>                       |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>504 S. DALLAS ST, BALTO. MD 21231</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY C PAESCH</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JOSEPHINE THOMAS</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-32-2655</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>DR. HUIE - UN. OF MD. HOSP.</b>                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ca. Breast &amp; Generalized metastasis</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>July 82</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/8</b> , 19 <b>84</b> , to <b>2/14</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>DR. HUIE</b>   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>2/14/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. HUIE</b>  |  | 22e. ADDRESS<br><b>THE UNIVERSITY OF MD. Hospital</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/17/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO.                                     |  |
|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                     |  |  |  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |  |
|  |  | THOMAS ROWLAND SLINGLUFF, JR.                           |  |  |  |  |  | FEBRUARY 13, 1984  |  | 11:49M                                       |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH                                     |  | 6. AGE   |  | 7. IF UNDER 1 YEAR   |  | 7. IF UNDER 24 HRS.                          |  |
| Male   |  | White   |  | Aug. 10, 1919  |  | 64   |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |  |  |  |
| MD   |  | USA   |  | NEVER MARRIED  |  | BALTIMORE CITY   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |  |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| BALTIMORE  |  | THE JOHNS HOPKINS HOSPITAL                              |  |  |  | Publisher- University Park Press                               |  |  |  |  |  |
| USUAL RESIDENCE  |  | 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS / ZIP CODE               |  |
| MD   |  |   |  | Balto.   |  | YES  |  | NO   |  | 6009 N. Charles St. 21212                    |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME                             |  |  |  |  |  |  |  |
| Thomas Rowland Slingsluff, Sr.   |  |   |  | Gertrude Seckel Jenkins                              |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |   |  | 16b. SOCIAL SECURITY NO.                             |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |
| Yes  |  |   |  | 218 07 6648  |  | Mrs. William A. Fisher, Jr., MD                                |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardio-respiratory arrest  |  |   |  |  |  |  |  |  |  | 5 days                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Presumed sepsis   |  |   |  |  |  |  |  |  |  | 2 years                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Colon Carcinoma  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |  |  |  |  |  |  |  |
| MEDICAL CERTIFICATION  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 1/19/84  |  | Metastatic Colon Carcinoma                              |  |  |  | YES  |  | NO   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING   |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED                             |  | 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |
| OR CONTRIBUTING  |  | HOUR A.M. MONTH DAY YEAR                                |  | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  | YES  |  |  |  |  |  |
| (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | P.M. 19   |  |  |  | NO   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION  |  | 21g. CITY OR TOWN  |  |  |  |  |  |
| WHILE AT WORK  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | STREET   |  | COUNTY   |  |  |  |  |  |
| NOT WHILE AT WORK  |  |   |  |  |  | STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/5/84 to 2/13/84, that (I) (we) lost saw the deceased alive on 2/13/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |  |  |
| m. Kelleff MD  |  |   |  |  |  |  |  | 2/13/84  |  |  |  |
| 22d. PHYSICIAN'S NAME  |  |   |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| M. Kelleff MD  |  |   |  | THE JOHNS HOPKINS HOSPITAL                           |  |  |  |  |  |  |  |
|  |  |   |  | 600 N. WOLFE ST. BALTO 1%, MD.                       |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                   |  | 23d. LOCATION  |  | 23e. DATE REC'D. BY REGISTRAR                                  |  |  |  |
| (SPECIFY)  |  | 2/15/84   |  | Green Mount  |  | Balto., MD   |  | FEB 16 1984  |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 24a. NAME   |  | 24b. ADDRESS   |  | 24c. CITY OR TOWN  |  | 24d. COUNTY  |  | 24e. STATE                                   |  |
|  |  | Henry W. Jenkins & Sons Co.                             |  | 4905 York Road Balto., MD 21212                      |  | Balto., MD   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for post-mortem examination.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |   |   |  |  |
|---|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William J. Sloman, Jr.</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 7, 1984</b>             |   |   | 2b. HOUR<br><b>1:30 A.M.</b>  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 9, 1946</b>   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>37</b> YRS.                 |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3703 Claremount Street</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>radio dispatcher</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>City of Baltimore</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>3703 Claremount Street, 21224</b>         |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William J. Sloman, Sr.</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Concetta DiMartino</b> |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-48-1418</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Concetta Sloman, 3703 Claremount St. 21224</b>  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4254</b> IMMEDIATE CAUSE (a) <b>Possible Ventricular Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Previous Myocardial Infarct</b> |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <b>Jan 24, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Michael F. Platt</b>   |  |  |  | DEGREE<br><b>Consulting</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/7/84</b>                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael F. Platt, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>841 S. ELLWOOD AVE 21224</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/10/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cardene of Faith</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Jos. N. Zandino 263 S. CONKLING</b>  |  |  |  | ADDRESS<br><b>21224</b>   |   | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1984</b>                   |  |  |
|   |  |  |  | 26. REGISTRAR'S SIGNATURE<br><b>John J. Coughlin</b>  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |   |                                       |  |   |  |  |  |  |   |  |                                       |  |
|---|--|--|---|---|---------------------------------------|--|---|--|--|--|--|---|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WALTER J. SLUGG, SR.</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 1, 1984</b>               |   | 2b. HOUR<br><b>9:36AM</b>             |  |   |  |  |  |  |   |  |                                       |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 16 1907</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |   |  |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |  |  |   |  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CRANE OPERATOR</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETH. STEEL</b>  |  |  |  |   |  |                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>   |  |  | 13b. COUNTY<br><b>-</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>525 N. CASTLE ST. 21205</b>   |  |  |   |  |                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM SLUGG</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CHARLOTTE SNIKERT</b> |   |                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |   |  |  | 16b. SOCIAL SECURITY NO.<br><b>188-01-5407</b> |  | 17. INFORMANT<br><b>PHYLLIS BOYNTON (DGHTR)</b> |  | ADDRESS<br><b>21206 5116 McFAULDR</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>OVERWHELMING PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CONGESTIVE HEART FAILURE</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |  |   |   |                                       |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>RENAL INSUFFICIENCY</b>  |  |  |   |   |                                       |  |   |  |  |  |  |   |  |                                       |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |   |  |  |  |  |   |  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |   |  |                                       |  |
| 22a. I certify that (1) (the hospital) attended the deceased from <b>JANUARY 14, 1984</b> to <b>FEBRUARY 1, 1984</b> , that (1) (we) last saw the deceased alive on <b>FEBRUARY 1, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (not) see the body after death.   |  |  |   |   |                                       |  |   |  |  |  |  |   |  |                                       |  |
| 22b. SIGNATURE<br><b>H. ARI JAFFE</b>   |  |  |   |   |                                       | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>2-1-84</b>                                  |  |  |   |  |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. ARI JAFFE</b>  |  |  |   |   |                                       | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |   |  |  |  |  |   |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>2/4/84</b>  |   |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |  |  |   |  |                                       |  |
| 24. FUNERAL DIRECTOR<br><b>SCHIMONEK FUNERAL HOME, INC.</b><br><b>3331 Brehms Lane, Balto. Md. 21213</b>  |  |  |   |   |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1984</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                |  |  |   |  |                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked B18, show any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



(A)

RECEIVED  
JAN 1 1950  
U.S. DEPT. OF JUSTICE

RECEIVED  
JAN 1 1950  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

RECEIVED  
JAN 1 1950  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AMANDA J. Smith</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-9-84</b>                    |   |  | 2b. HOUR<br>MIN.<br><b>4:45</b> M   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 24 28</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>YRS.<br><b>55</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE city, MD.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CITY BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>607 N. ROSEDALE ST</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Jenkins</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Thompson</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT<br>ADDRESS<br><b>Barbara Smith 1702 N. Warwick Avenue</b> |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PROBABLE INTRACEREBRAL HEMORRHAGE</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PREVIOUS INTRACEREBRAL HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>16 days</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>HYPERTENSION, CHRONIC ALCOHOLISM</b>  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/9</b> 19 <b>84</b> to <b>2/9</b> 19 <b>84</b> , that (I) <del>was</del> last saw the deceased alive on <b>2/9</b> 19 <b>84</b> , and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above. (I <del>will</del> <input checked="" type="checkbox"/> did <input type="checkbox"/> view the body after death. |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Stephen M. Seabron MD.</b>  |  |   |   | DEGREE<br><b>MD.</b>  |  |   |  | 22c. DATE SIGNED<br><b>2/9/84.</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHEN M. SEABRON</b>   |  |   |   | 22e. ADDRESS<br><b>1501 DIVISION ST. BALT. MD 21217.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>13a. <b>BURIAL</b>  |  | 23b. DATE<br><b>2/15/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>                                     |  |
| 25a. DATE REC'D. BY REGISTRAR  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>FEB 14 1984 John Davidson-Randell</b>  |  |   |  |  |  |

BP



Atlanta, Ga.

March 1, 1901

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours,  
Wm. C. March

Wm. C. March, Jr., President

First National Bank of Atlanta

Atlanta, Ga.

March 1, 1901

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First National Bank of Atlanta

Atlanta, Ga.

March 1, 1901

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DOROTHY SMITH</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 11, 84</b>  |  | 2b. HOUR<br><b>3:10AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 16 17</b>                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.<br>MONTHS DAYS HOURS MIN.          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Private Duty</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>G. Oscar Brown</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Thelma D. Holt</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8 Morrislea Court 21234</b>                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-32-9509</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Robert Smith - Same as #13.</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Hyperkalemia</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> 19 <b>83</b> to <b>2/11</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/11</b> 19 <b>84</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                       |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert A. Weisgar</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2/11/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. WEISGAR MD</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL BALTIMORE, MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>2/11/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  | ADDRESS<br><b>Balto., Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FFB 14 1984</b>                                  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>P. Davidson</b>   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (page 4 must be retained by the hospital or attending physician).

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | REG. NO. 04450  |   |  |  |  |  |  |
|--|--|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZA SMITH</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>02 05 84</b>          |   |  |  |  | 2b. HOUR <b>11-32A</b>                       |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 1 1910</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.                                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>domestic</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE <b>Ms.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>1308 Poplar Grove</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>David Jones</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE <b>Ella Punting</b>  |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>213-07-1412</b>   |   | 17. INFORMANT ADDRESS <b>Roselee Hall 1308 Poplar Grove</b>                                     |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4409 Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Arterio sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)     |  |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-1-</b> 19 <b>81</b> , to <b>2-5-</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-5-</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE <b>[Signature]</b>  |  |  |  |   |   | DEGREE <b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>2-6-84</b>               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. S. NAIR, M.D.</b>  |  |  |  |   |   | 22e. ADDRESS <b>5010 GORK Road BALTIMORE, MD 21212</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  |  | 23b. DATE <b>2-10-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Balto. MD.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Carlton C. Douglass</b>  |  |  |  | ADDRESS <b>1012 Penn Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

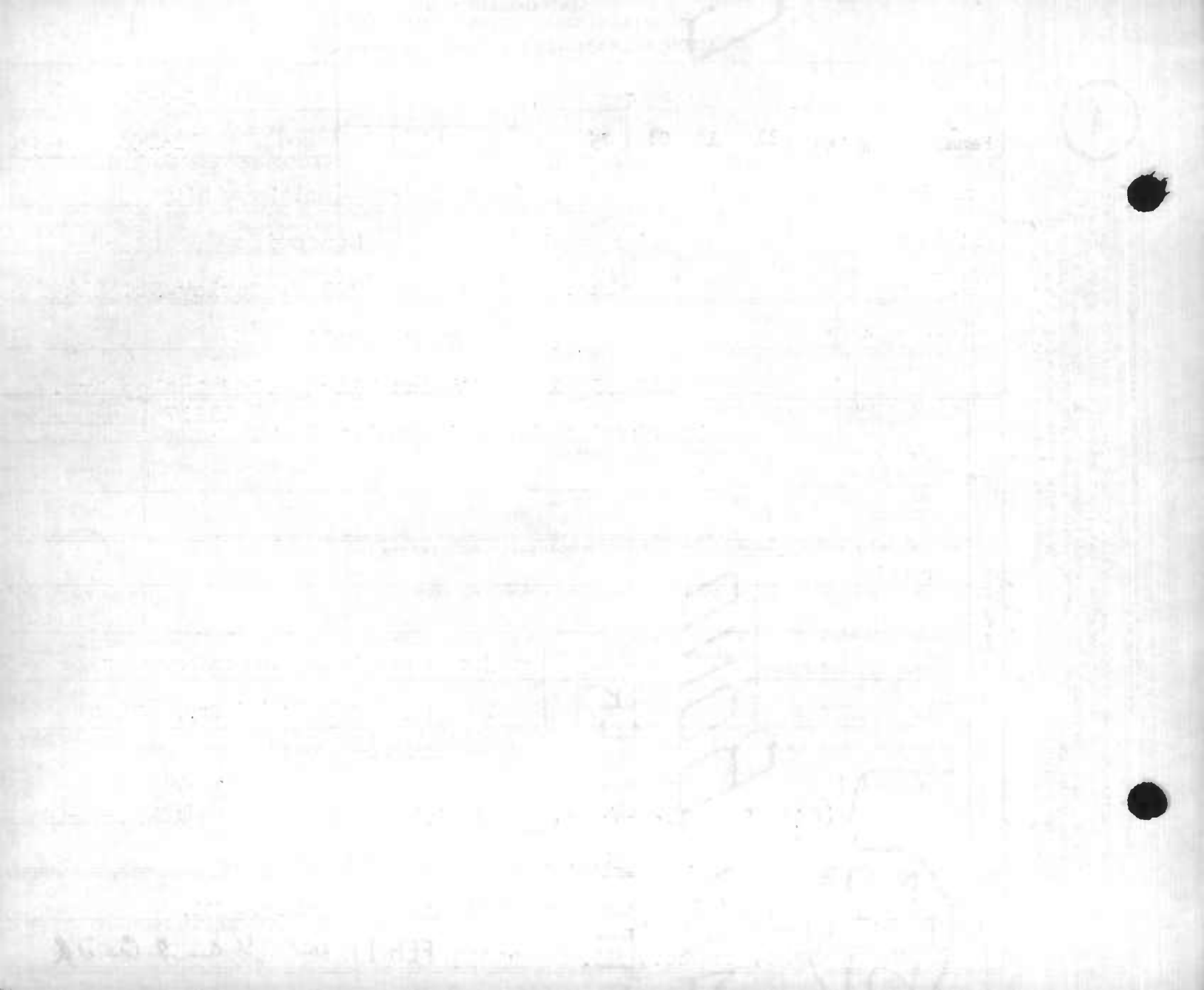
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04451

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |   |  |   |  |   |  |   |  |
|--|-------------------------|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLA KATHERINE SMITH</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2-9-84 19</b> |   |  | 2b. HOUR<br>M <b>12:58P</b>   |  |   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 18 08</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>75</b>  | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN  | 2c. DATE PRONOUNCED DEAD<br><b>2-9-84 19 12:58P</b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                    |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |   |  |   |  |   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>702 N. Curley St. 21205</b>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anton Hejduk</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Holin</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Vivian Fitch, 8106 Analee Ave.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>9104<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                |                         |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>21237</b>                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>drowning</b>   |                         |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input checked="" type="checkbox"/>   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 2-9-84 19</b>                               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject found in bathtub under water</b> |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>                               |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>702 Curley Street Baltimore, Maryland</b>                            |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>   |                         |   | TITLE (SPECIFY)<br><b>M.D. Assistant</b>   |   |  |   |  | DATE SIGNED<br><b>2-10-84</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         |   | ADDRESS<br><b>111 Penn Street</b>  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>2/13/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bohemian National</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Seaman Funeral Home, Inc.<br/>3331 Brehms Lane, Balto., Md.</b>   |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>21213</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>FEB 10 1984</b>  |  | 25c. REGISTRAR'S SIGNATURE<br><b>John J. Casper</b>                                 |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04452

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |
|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>EVELYN</u> MIDDLE <u>A.</u> LAST <u>SMITH</u><br><i>Evelyn A. Smith</i>  |  | 2a. DATE OF DEATH<br>MONTH <u>2</u> DAY <u>1</u> YEAR <u>84</u><br>2b. HOUR <u>1:55</u> AM <u>A</u>   |   |
| 3. SEX<br><u>FEMALE</u>  | 4. RACE<br><u>WHITE</u>  | 5. DATE OF BIRTH<br>MONTH <u>06</u> DAY <u>09</u> YEAR <u>20</u>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>   | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>63</u> YRS.<br>IF UNDER 1 YEAR: MONTHS <u>  </u> DAYS <u>  </u> IF UNDER 24 HRS. HOURS <u>  </u> MIN. <u>  </u> |   |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>ST. AGNES HOSPITAL</u> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>TELEPHONE OPERATOR</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>FT. MEADE</u>   |   |
| 13a. STATE<br><u>MARYLAND</u>  |  | 13b. CITY OR TOWN<br><u>BALTIMORE</u>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <u>FRANK</u> MIDDLE <u>  </u> LAST <u>SCOTT</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>CHRISTINE</u> MIDDLE <u>  </u> LAST <u>EYRING</u>  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>NO</u><br>(IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br><u>216-09-0354</u>  |   |
| 17. INFORMANT<br><u>FRANK G. SMITH</u>   |  | ADDRESS<br><u>594 S. BEECHFIELD AVENUE 21229</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>1552</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Multi-organ failure.</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>2 Carcinoma of the Liver</u>  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>  </u>   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |
| 22b. SIGNATURE<br><u>M. Elnow</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. ELNOW</u>  |  | 22c. DATE SIGNED<br><u>2/1/84</u>   |   |
| 22e. ADDRESS<br><u>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</u>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>  | 23b. DATE<br><u>02-04-84</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MEADOWRIDGE MEM. PK.</u>   | 23d. LOCATION<br>CITY OR TOWN <u>ELKRIDGE</u> COUNTY <u>HOWARD</u> STATE <u>MARYLAND</u>        |
| 24. FUNERAL DIRECTOR<br>NAME <u>HUBBARD FUNERAL HOME, INC.</u> ADDRESS <u>4107 WILKENS AVE.</u>  |  | 25a. DATE REC'D. BY REGISTRAR <u>FEB 3 1984</u> 25b. REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the required autopsy performed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR ANATOMY BOARD<br>STATE REGISTRAR  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IRVIN SMITH</b>   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 11, 1984</b>  |  |  |  |  |
| 3. SEX <b>MALE</b>   |  |  |  |  | 4. RACE <b>WHITE</b>   |  |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 12 1911</b>   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.   |  |  |  |  |
| 7a. BIRTHPLACE (COUNTRY) <b>Maryland</b>   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b> |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Multigraph</b>  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>  |  |  |  |  |
| 13a. STATE <b>MARYLAND</b>   |  |  |  |  | 13b. COUNTY <b>BALTIMORE</b>   |  |  |  |  |
| 13c. CITY OR TOWN <b>COCKEYSVILLE</b>  |  |  |  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |  |
| 13e. STREET ADDRESS / ZIP CODE <b>14400 CUBA RD 21030</b>  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Fredrich Norman SMITH</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINNIE Amelia DEHNE</b>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>218-12-0002</b>  |  |  |  |  |
| 17. INFORMANT ADDRESS <b>Mrs. Marjorie E. Smith - Same as #13.</b>   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>  |  |  |  |  |  |  |  |  |  |
| 4210 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |
| (b) <b>Pneumonia</b>   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |
| (c) <b>Bacterial Endocarditis</b>  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |  |  |  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |  |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/11 1984</b> to <b>2/11 1984</b> , that (I) (we) lost saw the deceased alive on <b>2/11 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>V Chang</b> DEGREE   |  |  |  |  |  |  |  |  |  |
| 22c. DATE SIGNED <b>2/11/84</b>  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V Chang</b>   |  |  |  |  |  |  |  |  |  |
| 22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>   |  |  |  |  |  |  |  |  |  |
| 23b. DATE <b>2/13/84</b>   |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>  |  |  |  |  |  |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>   |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>R. Hudson-Rendell</b>  |  |  |  |  |  |  |  |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |   |  |                                   |  |   |
|---|--|---|---|--|-----------------------------------|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Louisa G. Smith  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 22 84  |  |                                   | 2b. HOUR<br>12:31 PM   |   |
| 3. SEX<br>F   | 4. RACE<br>B   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 26 09   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  | IF UNDER 24 HRS.<br>HOURS MIN.                          |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>West Indies   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |  |                                   |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Pleasant Manor Nursing Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   | 13a. STREET ADDRESS<br>4224 Fairview Ave. 21215   |  |                                   |  |   |
| 13a. STATE<br>Md.   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nestie Thomas   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Veronica Dumford   |   |  |                                   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>134-26-7128   |   | 17. INFORMANT ADDRESS<br>Pleasant Manor nursing Center<br>4615 Park Heights Ave. Balto., Md.   |                                   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Generalized senile arteriosclerosis</u><br>12 mor.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 min. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |                                   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-15</u> , 19 <u>83</u> , to <u>2-22</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2-22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |                                   |  |   |
| 22b. SIGNATURE<br><u>Samuel Ponzalan MD</u>   |  | DEGREE  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br>2/23/84  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |                                   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2-27-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto, H.C. Maryland   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Chas. A. Rice FSPA 1300 Eutaw Pl  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 28 1984   |                                   | 25b. REGISTRAR'S SIGNATURE<br><u>Lelia Davidson-Randall</u>  |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1515

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04455

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lucille Bell Smith</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 17 84</b>  |   | 2b. HOUR<br><b>6<sup>35</sup> AM</b>                                     |
| 3 SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 16 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>  | YRS. MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Qual. Cont. Insp.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Glass</b>                        |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2910 Clifton Park Terrace 21213</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Luther Williamson</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Browning</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>236-16-2610</b>  |  | 17. INFORMANT<br><b>Mrs. Genene Saxton, 3335 Kenyon Avenue Baltimore, Md. 21213</b>             |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) **sepsis**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) **pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(c) **renal + hepatic failure, immunodeficiency**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

**ischemic gallbladder + stomach**

|  |   |   |   |
|--|---|---|---|
| 19a. DATE OF OPERATION<br><b>1/19/84</b> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ischemic gallbladder + stomach</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|--|---|---|---|

|  |   |  |
|--|---|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|--|---|--|

|  |  |   |
|--|--|---|
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |
|--|--|---|

22a. I certify that (I) (this hospital) attended the deceased from **2/1/84**, 19 **84**, to **2/17**, 19 **84**, that (I) (we) last saw the deceased alive on **2/17**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|                                 |                       |  |                                    |
|---------------------------------|-----------------------|--|------------------------------------|
| 22b. SIGNATURE<br><b>A. Lee</b> | DEGREE<br><b>M.D.</b> | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>2/17/84</b> |
|---------------------------------|-----------------------|--|------------------------------------|

|   |  |
|---|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. Andrew Lee</b> | 22e. ADDRESS<br><b>Dept. of Surgery, Baltimore City Hospital</b> |
|---|--|

|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>2-20-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md.</b> |
|---|-----------------------------|--|--|

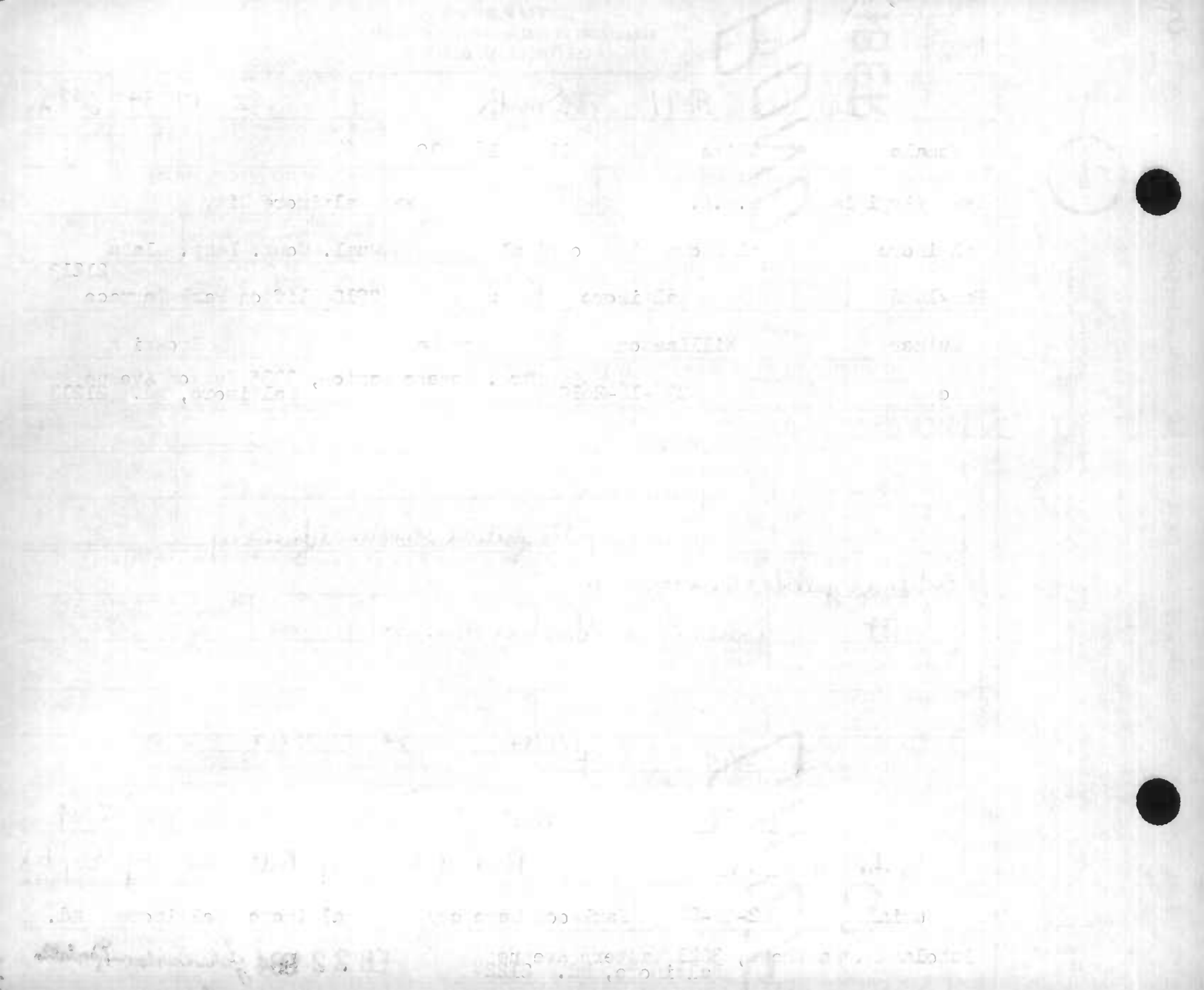
|   |   |   |
|---|---|---|
| 24. FUNERAL DIRECTOR<br><b>Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md. 21224</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1984</b> | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b> |
|---|---|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours after death, it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04456

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                          |   |  |
|--|--|---|---|---|--------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LUCY SMITH</b>    |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-12-84</b> |   | 2b. HOUR<br><b>9:15A</b> |   |  |
| 3. SEX<br><b>FEMALE</b>                                  |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 15 04</b>  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b><br>YRS. MONTHS DAYS HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT.</b>                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GEN. HOSP</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR LOSS OF WORKING LIFE)<br><b>NONE</b>  |                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MD.</b>   |  |
| 13a. STATE<br><b>MD</b>                                  |  | 13b. COUNTY<br><b>BALT</b>  |   | 13c. CITY OR TOWN<br><b>BALT</b>  |                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unkn</b>    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Liza Hill</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                          | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>237-62-5482</b>                   |  |
| 17. INFORMANT<br>ADDRESS<br><b>HOSP. CHART</b>           |  |   |   |   |                          |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**

**0389**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASPIRATION PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

(c) **SEPSIS, SEIZURE DISORDER**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

**URINARY TRACT INFECTION. Possible non-pulmonary Tuberculosis.**

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>J. Douglas Clarke, M.D.</b>                       |  | 22c. DATE SIGNED<br><b>2/12/84</b>  |  | 22d. ADDRESS<br><b>8001 50 HANOVER ST., BALT., MD.</b>  |  |

MEDICAL CERTIFICATION

|   |  |                                      |  |  |  |   |  |
|---|--|--------------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>2/18/84</b>          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Betsy Chapel Ch Cem</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Tarboro N.C.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>         |  | ADDRESS<br><b>1101 E. North Ave.</b> |  | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1984</b>               |  | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4-11-11

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*[Faint, mostly illegible handwritten text and markings covering the majority of the page. Some words like "SUN" and "MAY" are faintly visible.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04457

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |  |                                   |   |  |
|---|--|---|---|---|--|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET Marie SMITH</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 14 84</b> |   |  | 2b. HOUR<br><b>M</b>  |  |  |                                   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 3 1904</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>79</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |                                   | 7. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1936 Penhall Road 21222</b>   |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Rappold</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Biedenbach</b>   |  |   |  | 16. ADDRESS<br><b>1936 Penhall Rd. Balto., MD. 21222</b>   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-07-0594</b>   |   | 17. INFORMANT<br><b>Dolores Strobach</b>  |  |   |  | 17. ADDRESS<br><b>Balto., MD. 21222</b>  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Recurrent supra-ventricular tachycardia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>years</b> |  |   |   |   |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chronic renal failure</b>  |  |   |   |   |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/25/84</b> , 19____, to <b>2/14/84</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>2/14/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |                                   |   |  |
| 22b. SIGNATURE<br><b>B. Matos, MD</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>2/11/84</b>   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. MATOS, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>21 CRANTBROOK RD COCKEYSVILLE MD 21030</b>   |  |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/18/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.</b>  |  |   |   | ADDRESS<br><b>Dundalk, Inc.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 17 1984 Julia Davidson-Randall</b>                      |                                   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified and a medical examination must be performed.

BP \_\_\_\_\_

DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  | 2b. HOUR  |  |
| Marie Catherine Smith   |  |   |  |   |  |   |  | 2-29-84  |  | 3:05P.M.  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 7b. IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| Female  |  | White   |  | 9 13 17   |  | 66  |  |  |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |   |  |
| Maryland  |  | U.S.A.  |  |   |  | Baltimore City MD.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| Baltimore   |  | St. Agnes Hospital  |  |   |  | Homemaker   |  | ---  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |   |  |
| Maryland  |  |   |  | Baltimore   |  |   |  | 1802 Spence Street 21223   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |   |  |
| William Baum  |  |   |  | Bertha Unknown  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |   |  |
| NO  |  | 216-07-0299   |  | Sharon Thompson   |  | 1802 Spence St. 21223   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>SEPSIS WITH HYPOTENSION</u><br><u>2028</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>URINARY TRACT INFECTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>LYMPHOMA</u>    |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u><br><u>1 wk</u><br><u>8 months</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>LEUKOPENIA, THROMBOCYTOPENIA</u>  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>2-23</u> , 19 <u>84</u> , to <u>2-29</u> , 19 <u>84</u> , that (I) <u>lost</u> saw the deceased alive on <u>2-29</u> , 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>viewed</u> (did not view) the body after death. |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Paul Gormley</u>   |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><u>2/29/84</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>PAUL GORMLEY</u>  |  |   |  | 22e. ADDRESS<br><u>900 CATON AVE BALTO. MD.</u>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| Burial  |  | 3/5/84  |  | Cedar Hill Cemetery   |  | Brooklyn Pk. A.A. Maryland  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |  | 25a. DATE REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229  |  |   |  | MAR 2 1984  |  | <u>Julia Davidson-Randall</u>   |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |   |  |  |  | REG. NO.  |  |
|---|--|--|---|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary E. (LIZZIE) Smith</b>   |  |  |   |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>01</b> YEAR <b>84</b>                                  |   |  | 2b. HOUR<br><b>6:30 A.M.</b>   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>02</b> YEAR <b>20</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                     |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>unemployed</b>           |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>md</b>  |  | 13b. COUNTY<br><b></b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2531 Hollins Street 21223</b>                 |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b></b> LAST <b>Rogers</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Minnie</b> MIDDLE <b></b> LAST <b>Clark</b><br><b>(Mack)</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-22-7911</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Edward Smith 2531 Hollins Street</b><br><b>inpatient record</b>  |   |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio. pulmonary arrest</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pulmonary embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Congestive heart failure</b> |  |  |   |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>peripheral vascular occlusive disease</b>  |  |  |   |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>2/10/84</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b></b>       |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b> |   |   | 21f. LOCATION<br>STREET<br><b></b>  |  |  | CITY OR TOWN<br><b></b>  |   |  |
| 21g. COUNTY<br><b></b>  |  |  | 21h. STATE<br><b></b>   |   |   | 21i. CITY OR TOWN<br><b></b>  |  |  | 21j. COUNTY<br><b></b>   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/10/84</b> to <b>2/11/84</b> , that (I) (we) last saw the deceased alive on <b>2/10/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |  |   |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Gayoso</b>   |  |  |   |   | DEGREE<br><b>M.D.</b>   |   |  | 22c. DATE SIGNED<br><b></b>  |  | 22d. ADDRESS<br><b></b>                                 |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gayoso</b>  |  |  |   |   | 22f. ADDRESS<br><b></b>   |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>2/15/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>                                   |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Owings Mills,</b> COUNTY <b></b> STATE <b>Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>  |  |  |   |   | ADDRESS<br><b>1101 E North Avenue</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1984</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |  |



3

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

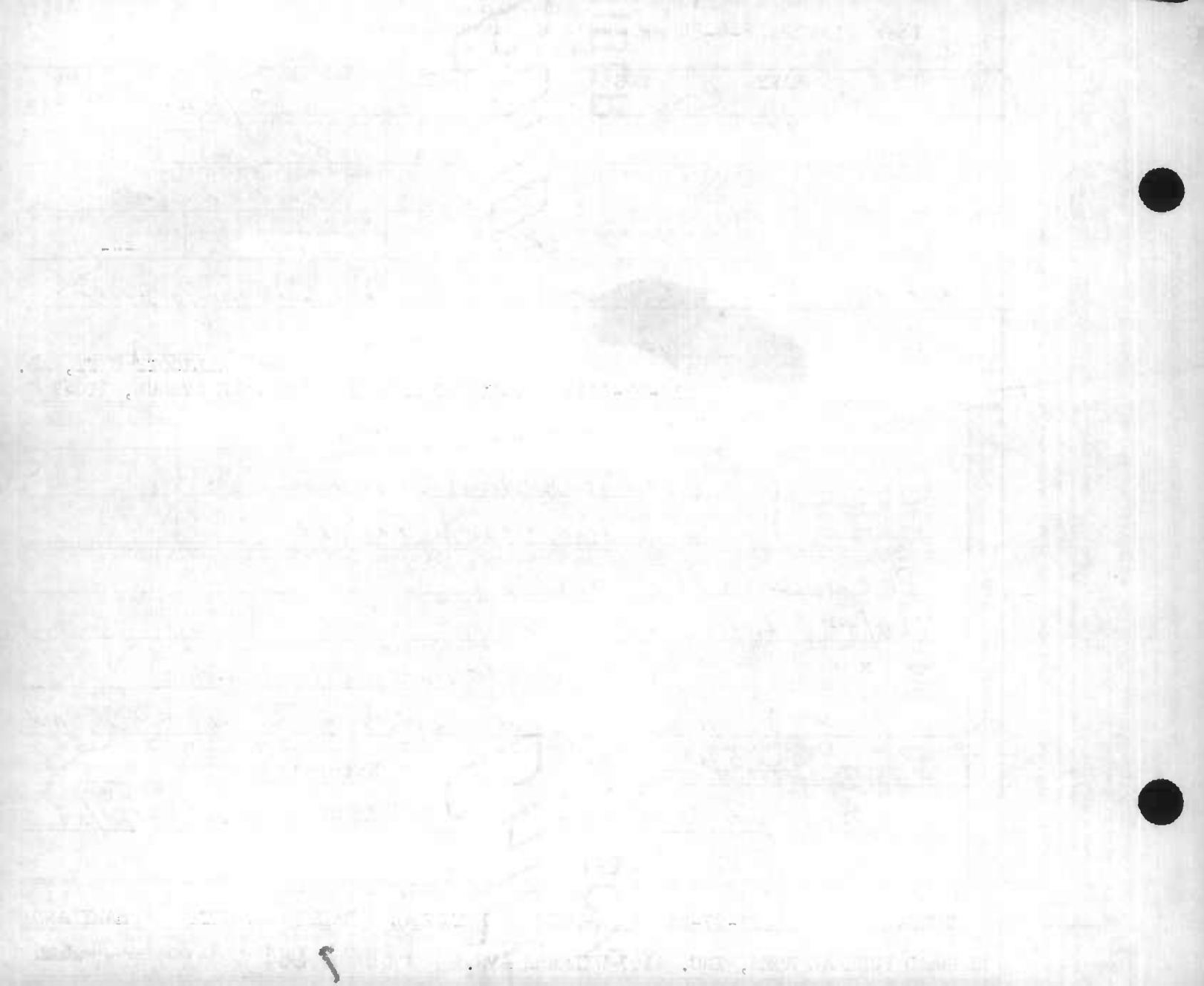


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  | 0 4 4 6 0  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| Item 21a&22a 8-4-84   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Mary Rose Smith</u>  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH <u>2</u> DAY <u>24</u> YEAR <u>84</u>   |  |  |  |  |  |  |  |  |  | 2b. HOUR<br><u>4:00AM</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><u>Female</u>   |  |  |  |  |  |  |  |  |  | 4. RACE<br><u>Caucasian</u>  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>MONTH <u>1</u> DAY <u>19</u> YEAR <u>48</u>  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>86</u> YRS MONTHS <u>0</u> DAYS <u>0</u>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>SBGH</u> |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>HOMEMAKER</u>   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>---</u>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br><u>md</u>   |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br><u>---</u>  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br><u>Baltimore</u>  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br><u>607 South Monroe St. 21223</u>       |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <u>Stanley</u> MIDDLE <u>---</u> LAST <u>Norville</u>  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>UNKNOWN</u> MIDDLE <u>---</u> LAST <u>---</u>                                       |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><u>215-07-6880</u>   |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br><u>REGINALD MALLOY</u> ADDRESS <u>ELLICOTT CITY, MD.</u> |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br><u>4280</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Chronic Obstructive Pulmonary Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Constrictive Heart Failure</u> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>---</u>   |  |  |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia/Osteoporosis</u> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>1/26/84</u>  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Left Hip Fracture</u>   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>1</u> <u>23</u> <u>1984</u>                                   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>Patient fell at home</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>Home</u>                                    |  |  |  |  |  |  |  |  |  | 21f. LOCATION<br>STREET <u>607 South Monroe</u> CITY OR TOWN <u>Baltimore</u> COUNTY <u>Baltimore</u> STATE <u>MD</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> to <u>2/24</u> 19 <u>84</u> , that (II) (we) lost<br>saw the deceased alive on <u>2/23</u> 19 <u>84</u> , and that in my (aur) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death.  |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br><u>George A. Williamson</u> DEGREE <u>---</u>  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br><u>2/24/84</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>George A. Williamson</u>  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br><u>SBGH</u>  |  |  |  |  |  |  |  |  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>   |  |  |  |  |  |  |  |  |  | 23b. DATE<br><u>02-27-84</u>   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>BALTIMORE NATIONAL</u>  |  |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN <u>BALTIMORE CITY</u> COUNTY <u>MARYLAND</u>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>HUBBARD FUNERAL HOME, INC.</u> ADDRESS <u>4107 WILKENS AVE.</u>   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 27 1984</u>  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randell</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04461

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |  |  |  |
|---|--|---|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mildred R. Smith   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 13 1984                   |   |   | 2b. HOUR<br>9:45p M  |   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 12, 1921   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.   |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Nurse    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Health Care   |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>429 Academy Road 21228 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ross Rowe   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Olive Holstein   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>220-22-3019                                |   | 17. INFORMANT<br>ADDRESS 52 N. Prospect Avenue<br>Michael J. Smith - Baltimore, Md. 21228 |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4275 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which }<br>gave rise to immediate }<br>cause (a), stating the }<br>underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) }<br>Cardiorespiratory arrest |  |   |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)            |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (we) (this hospital) attended the deceased from 2/10, 19 84, to 2/13, 19 84, that (we) lost<br>saw the deceased alive on 2/13, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (do not) view the body after death.  |  |   |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br>BERT F. MORTON  |  |   |  |   | DEGREE<br>M.D.  |  |   | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERT F. MORTON   |  |   |  |   | 22e. ADDRESS<br>900 S. Caton Ave., Baltimore, Md. 21229                                   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br>Cremation   |  |   | 23b. DATE<br>2/18/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial Park                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Md.                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John Harrison Handell   |  |  |  |

BP



Item #16a G589 3/14/84 cw

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 4 4 6 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

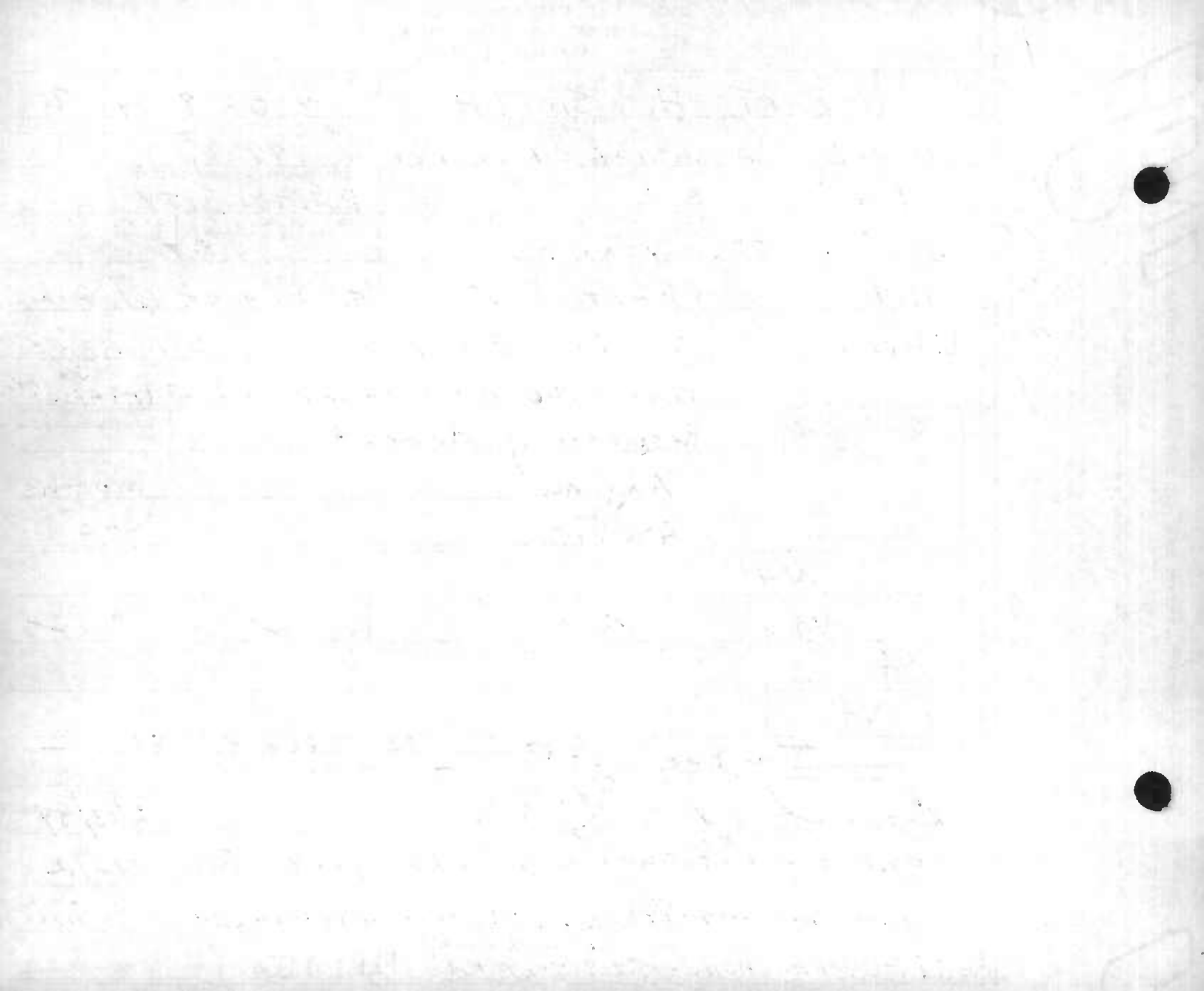
|   |  |  |   |   |  |  |   |
|---|--|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT H. SMITH</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>~ 02 8 84</b> |   |  | 2b. HOUR <b>?</b> M  |   |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>04 01 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH <b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5220 YORK Rd.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE <b>md.</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN <b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |   |
| 13e. STREET ADDRESS <b>5220 YORK Rd. 21212</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>David Smith</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Emma Simmons</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>172-05-4716</b>  |   | 17. INFORMANT <b>MS. NORA WIRTH-2138 PATAPSCO</b>   |  | ADDRESS <b>21230 AV.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>4130</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Angina</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b>                             |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>months</b><br><b>y-s</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>NA</b>   |  |  |   |   |  |  |   |
| 19a. DATE OF OPERATION <b>NA</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NA</b>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NA <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this <del>person</del> ) attended the deceased from <b>Sept</b> 19 <b>83</b> , to <b>Feb 8</b> 19 <b>84</b> , that (I) <del>was</del> lost<br>saw the deceased <del>while</del> <b>~ Dec. 19 83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above. (If <del>any</del> did, <del>join</del> view the body after death.) |  |  |   |   |  |  |   |
| 22b. SIGNATURE <b>Bannister L. Raines, Jr.</b> DEGREE <b>M.D.</b>   |  |  |   | 22c. DATE SIGNED <b>2/13/84</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bannister L. Raines, Jr.</b>  |   |
| 22e. ADDRESS <b>5225 York Rd 21212</b>  |  |  |   | 22f. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>  |  | 22g. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>CREMATION</b>   |  | 23b. DATE <b>2-14-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>BALTIMORE md.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Redd FUNERAL Home- 5209 YORK Rd.</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>  |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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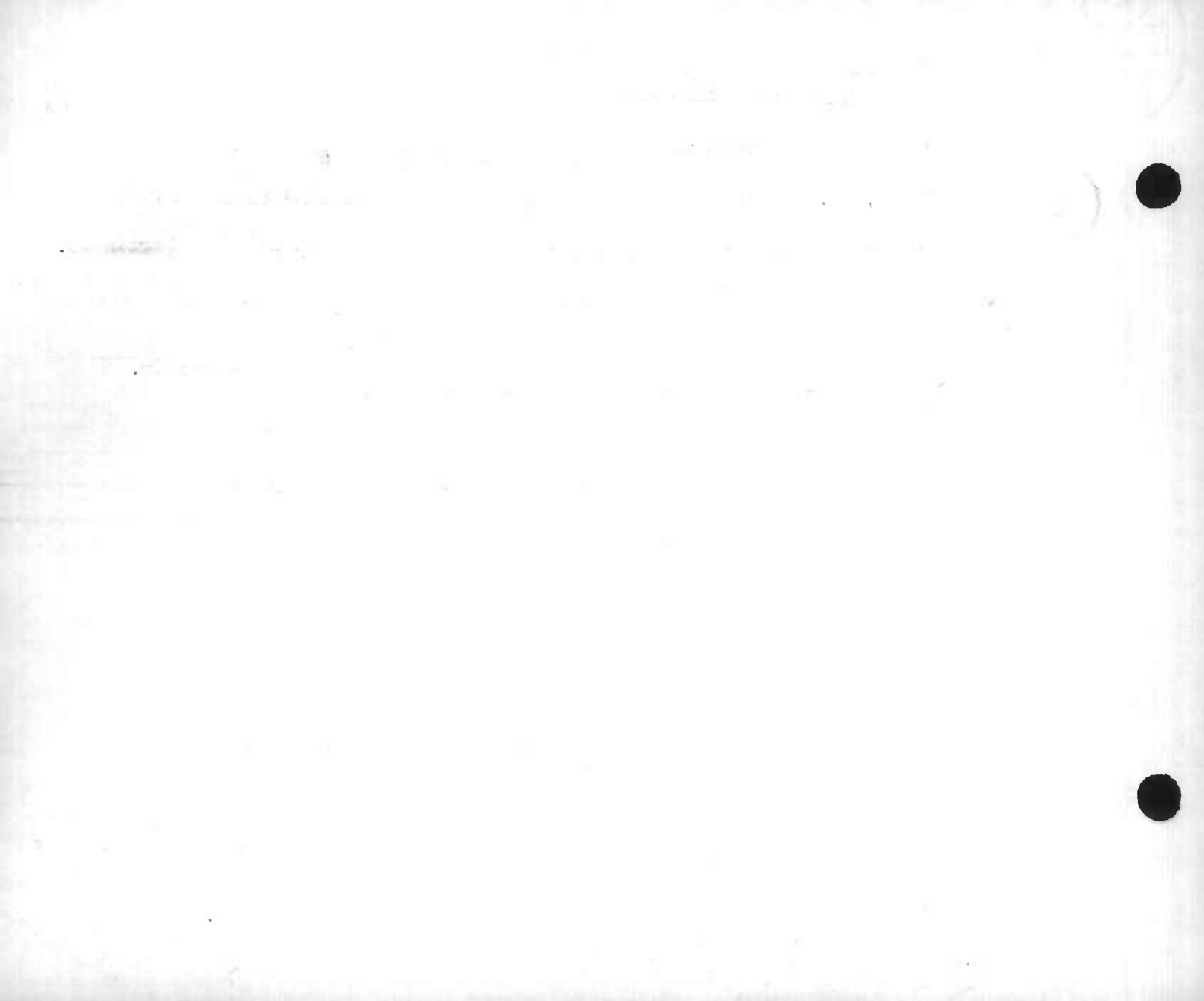
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as "item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 must be filled in."

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                         |   |   |   | REG. NO.                                     |   |
|---|-------------------------|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM ELMER SMITH</b>  |                         |   | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>15</b> YEAR <b>84</b> |   | 2b. HOUR<br><b>5:26 AM</b>                   |   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH <b>09</b> DAY <b>22</b> YEAR <b>1897</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> <small>86RS</small>                  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>  |   | 10. IF UNDER 24 HRS<br>HOURS <b>00</b> MIN. <b>00</b>                             |  |   |
| 11. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |                         | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |   | 13. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b> |  |   |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE <b>MARYLAND</b> 14b. COUNTY <b>Baltimore</b> 14c. CITY OR TOWN <b>BALTIMORE</b>   |                         | 15. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 16. STREET ADDRESS / ZIP CODE<br><b>1, GOELLER AVE. BALTIMORE, MD 21221</b>       |  |   |
| 17. FATHER'S NAME<br>FIRST <b>Unknown</b> LAST <b>Unknown</b>   |                         | 18. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>  |   | 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>     |  |   |
| 20. SOCIAL SECURITY NO.<br><b>215-07-9167</b>   |                         | 21. INFORMANT<br><b>Doris Bradford</b>  |   | 22. ADDRESS<br><b>1870 Westwood Dr.</b>   |  |   |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>5188</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC PULMONARY DISEASE</b>                                   |                         |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |                         |   |   |   |  |   |
| 24a. DATE OF OPERATION  |                         | 24b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 24c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |   |
| 25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 25b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)     |  |   |
| 26a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 26b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 26c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |
| 27. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 20, 19 84</b> , to <b>FEBRUARY 15, 19 84</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 15, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                         |   |   |   |  |   |
| 28a. SIGNATURE<br><b>Edwin Yeo</b>  |                         | 28b. DEGREE<br><b>M.D.</b>  |   | 28c. DATE SIGNED<br><b>2/15/84</b>  |  |   |
| 29a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDWIN YEO</b>   |                         | 29b. ADDRESS<br><b>1109 (C) E. BELVEDERE AVE BALTIMORE, MD 21239</b>  |   |   |  |   |
| 30a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Funeral</b>  |                         | 30b. DATE<br><b>2/18/84</b>   |   | 30c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                    |  |   |
| 30d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Baltimore Md. Baltimore-Pendle</b>   |                         | 31. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>   |   |   |  |   |
| 32. FUNERAL DIRECTOR<br><b>Bohdzinski Funeral Home PA 1407 Old Eastern Ave</b>  |                         | 33. DATE RECEIVED BY REGISTRAR<br><b>FEB 21 1984</b>  |   |   |  |   |
| 34. REGISTRAR'S SIGNATURE   |                         | 35. REGISTRAR'S SIGNATURE   |   |   |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal case must be notified to the State Dept. of Health and Mental Hygiene.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | REG. NO.            |   |  |
|---|--|--|--|---|---------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE A. LAST SMULLIAN   |  |  | 2a. DATE OF DEATH<br>MONTH FEBRUARY DAY 17 YEAR 1984 |   | 2b. HOUR<br>6 A. M. |   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH APRIL DAY 12 YEAR 1905  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6310 GREENSPRING AVE. APT. 105  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST NATHAN MIDDLE A. LAST LEVY   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST ESTHER MIDDLE LEAH LAST UNKNOWN  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |                     | 16b. SOCIAL SECURITY NO.<br>217-03-7840   |  |
| 17. INFORMANT<br>RONALD M. SMULLIAN   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac artery thrombosis</i><br>1820<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Electrolyte imbalance</i><br>(c) <i>Pelvic Carcinoma of ovary</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>acute</i><br><i>7 days</i><br><i>3 yrs</i>   |                     |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.  |  |  |  |   |                     |   |  |
| 19a. DATE OF OPERATION<br>? 1980  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Ca endometrial</i>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                     |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <i>MAY 3 1980</i> to <i>Feb 17 1984</i> , that (1) (we) lost saw the deceased alive on <i>2-15 1984</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |                     |   |  |
| 22b. SIGNATURE<br><i>H. Gerald Oster m</i>  |  | 22c. DATE SIGNED<br>2-17-84  |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |                     | 22e. ADDRESS<br>3635 Old Court Rd.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2/19/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH TFILOH CEM   |                     | 23d. LOCATION<br>CITY OR TOWN BALTIMORE COUNTY MARYLAND STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |                     | 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked other than 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |  |  | REG. NO.  |   |
|--|---|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George Sommers  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/11/84                               |  | 2b. HOUR<br>1145 AM   |   |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 15 1922   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. City Hosps. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Nestley Co.            |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 13e. STREET ADDRESS / ZIP CODE<br>508 Fairview Avenue 21224 |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Julius Sommers   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Irene McCord   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>Yes WW II |   |   |
| 16b. SOCIAL SECURITY NO.<br>214-18-6922  |   | 17. INFORMANT<br>Julius A. Sommers  |  | 17. ADDRESS<br>5930 Daybreak Terrace<br>Balto., MD. 21206  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>mesenteric vein thrombosis</u><br>5715 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>embolus</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 wk<br>1 wk<br>years   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.   |   |   |  |  |   |   |
| 19a. DATE OF OPERATION<br>1/23/84  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>acute abdomen   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                          |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/23</u> , 19 <u>84</u> , to <u>2/11</u> , 19 <u>84</u> , that (1) (we) lost saw the deceased alive on <u>2/11/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.                    |   |   |  |  |   |   |
| 22b. SIGNATURE<br><u>Michael G. Sarr</u>   |   | DEGREE  |  | 22c. DATE SIGNED<br>2/11/84  |   | 22d. ADDRESS<br>Balto City Hospitals, Balto, MD   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael G. Sarr   |   | 22f. ADDRESS  |  | 22g. DATE REC'D. BY REGISTRAR  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |   | 23b. DATE<br>2/2/1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222   |   |   |  | 25. REGISTRAR'S SIGNATURE<br>FEB 7 1984  |   |   |

April 18 11/5

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11/5

*[Faint, mostly illegible handwriting throughout the page, possibly a ledger or account book entry.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

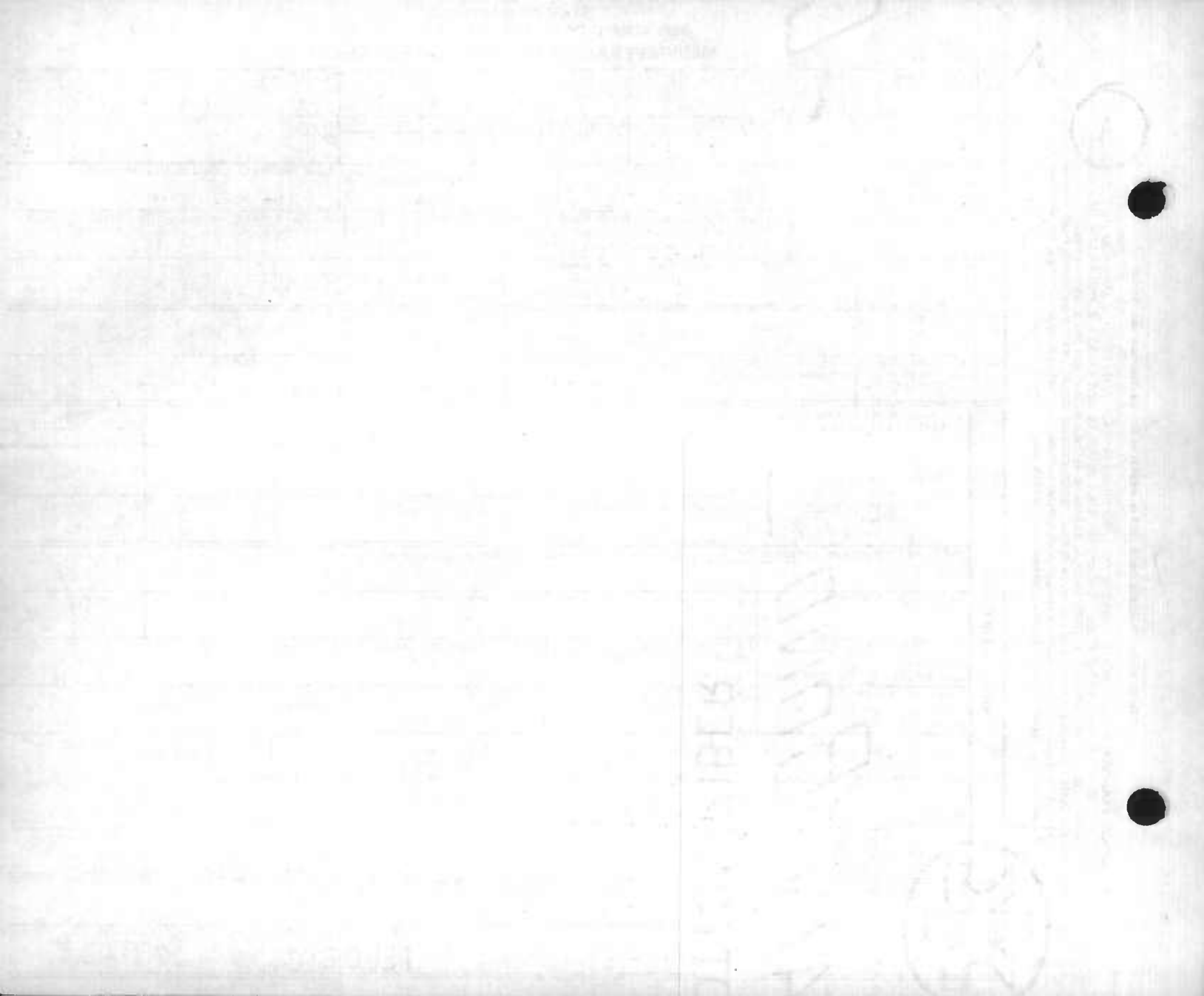
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |                                    |   |                                  |   |       |                                      |           |   |
|--|---------|--|------------------------------------|---|----------------------------------|---|-------|--------------------------------------|-----------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  | MIDDLE                             | LAST  | 2. DATE KNOWN<br>OF DEATH        |   | MONTH | DAY                                  | YEAR      | 26. HOUR  |
| CLINTON  |         |  |                                    | SOMMERVILL  | (SUMMERVILLE)                    |   |       |                                      | 2 2 19 84 | M   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY | 7. IF UNDER 1 YR.<br>MONTHS DAYS  | 8. IF UNDER 24 HRS.<br>HOURS MIN | 9. DATE<br>PRONOUNCED<br>DEAD   | MONTH | DAY                                  | YEAR      | 24. HOUR  |
| Male   | Black   | 4 1 15   | 68 YRS.                            |   |                                  |   |       |                                      | 2 4 19 84 | 12:55<br>P.M.                                   |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |       |                                      |           |   |
| N. Carolina  |         | U.S.A.   |                                    |   |                                  | Baltimore City  |       | MD.                                  |           |   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |   |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |       | 12b. KIND OF BUSINESS<br>OR INDUSTRY |           |   |
| Baltimore  |         | 1841 N. Caroline St.   |                                    |   |                                  |   |       |                                      |           |   |
| 13a. STATE   |         | 13b. COUNTY  |                                    | 13c. CITY OR TOWN   |                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 13e. STREET ADDRESS                  |           |   |
| Maryland   |         |  |                                    | Baltimore   |                                  |   |       | 1841 N. Caroline St. 21213           |           |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |                                    |   |                                  |   |       |                                      |           |   |
| Henry  |         | Sommerville  |                                    | Susie   |                                  | Staten  |       |                                      |           |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT   |                                  | ADDRESS   |       |                                      |           |   |
| UNKNOWN  |         | 240-14-1453A   |                                    | Marjorie Alexander  |                                  | 1112 21st St NE   |       |                                      |           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                  |         |  |                                    |   |                                  |   |       |                                      |           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |  |                                    |   |                                  |   |       |                                      |           |   |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |   |                                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |       |                                      |           |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                  |   |       |                                      |           |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |   |       |                                      |           |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |                                    |   |                                  |   |       |                                      |           |   |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |                                    |   |                                  | DATE SIGNED 2-5-84  |       |                                      |           |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |                                    |   |                                  |   |       |                                      |           |   |
| Ann M. Dixon, M.D.   |         | 111 Penn St., Balto., Md. 21201  |                                    |   |                                  |   |       |                                      |           |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |                                    | 23c. NAME OF CEMETERY OR CREMATORY  |                                  | 23d. LOCATION<br>CITY OR TOWN   |       | COUNTY                               |           | STATE   |
| BURIAL   |         | 2/10/84  |                                    | Alexander Family Cem Enfield,   |                                  |   |       |                                      |           | N.C.  |
| 24. FUNERAL DIRECTOR<br>NAME   |         |  |                                    | 25a. DATE REC'D. BY REGISTRAR   |                                  | 25b. REGISTRAR'S SIGNATURE  |       |                                      |           |   |
| Wm C March F/H Inc. 1101 E North Avenue  |         |  |                                    | FEB 08 1984   |                                  | John J. Carver  |       |                                      |           |   |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

04467

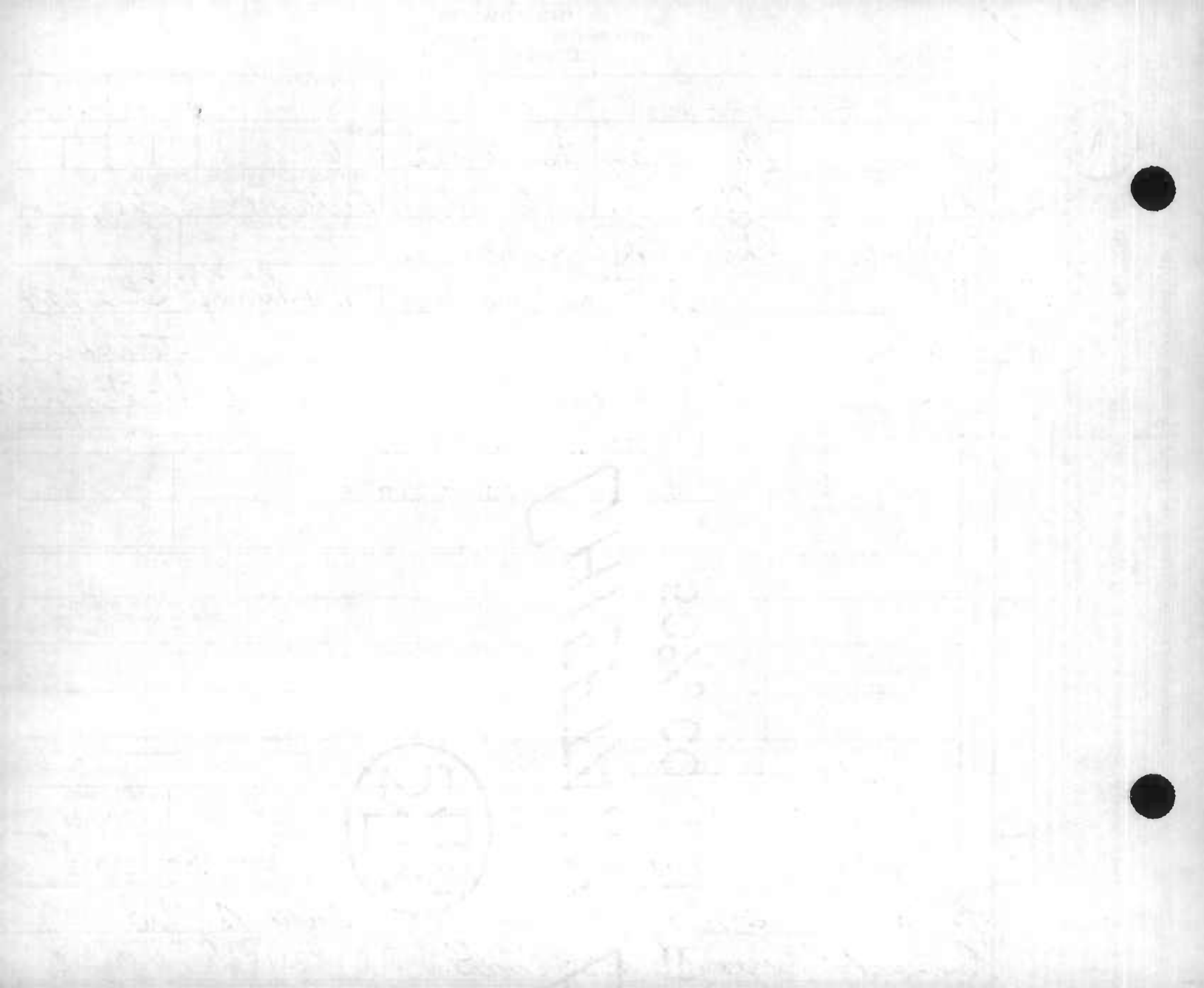
1- FOR  
STATE  
REGISTRAR

|   |  |   |                   |   |  |   |  |  |  |  |  |  |  |
|---|--|---|-------------------|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | 2a. DATE OF DEATH |   |  | MONTH   |  | DAY  |  | YEAR   |  | 2b. HOUR                                     |  |
| JOSEPH SOWINSKI   |  |   | FEBRUARY          |   |  | 4   |  | 1984   |  | 6:45 PM  |  |  |  |
| 3. SEX  |  | 4. RACE   |                   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |  |  |
| Male  |  | Caucasian   |                   | May 18, 1922  |  | 61  |  | YRS.   |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |  |  |
| Md.   |  | U. S. A.  |                   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | Baltimore City  |  |  |  |  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |  |  |
| Baltimore   |  | Church Hosp. Inc.                                       |                   |   |  |   |  |  |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |                   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |  |  |
| Md.   |  |   |                   | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 404 Tolcroft St  |  | 21224  |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                |                   |   |  |   |  |  |  |  |  |  |  |
| Stanley   |  | Sowinski  |                   | Agnes   |  | Stempor   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.                                |                   | 17. INFORMANT   |  | ADDRESS   |  |  |  |  |  |  |  |
| Yes <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/> WWII   |  | 217-16-7866   |                   | Mrs Mary Sowinski   |  | 404 Tolcroft St   |  | 21224  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |                   |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |                   |   |  |   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) RESPIRATORY ARREST  |  |   |                   |   |  |   |  |  |  |  |  |  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF   |  |   |                   |   |  |   |  |  |  |  |  |  |  |
| (b) OAT CELL CANCER OF THE LUNG   |  |   |                   |   |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |                   |   |  |   |  |  |  |  |  |  |  |
| (c)   |  |   |                   |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |                   |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|   |  |   |                   |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |                   | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
|   |  |   |                   | HOUR A.M. MONTH DAY YEAR  |  |   |  |  |  |  |  |  |  |
|   |  |   |                   | P.M. 19   |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |   |                   | 21e. PLACE OF INJURY  |  |   |  | 21f. LOCATION  |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |  |   |                   | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| AT WORK   |  |   |                   |   |  |   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 13, 1984, to FEBRUARY 2, 1984, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on FEBRUARY 2, 1984, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |                   |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |   |                   | DEGREE  |  |   |  | 22c. DATE SIGNED   |  |  |  |  |  |
| Mark M. Gaughy  |  |   |                   | M.D.  |  |   |  | 2/4/84   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |                   | 22e. ADDRESS  |  |   |  |  |  |  |  |  |  |
| MARK MCGAUGHY   |  |   |                   | CHURCH HOSP. 100 NORTH BROADWAY   |  |   |  | 21231  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   |                   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION  |  |  |  |  |  |
| Burial  |  |   |                   | 2-7-84  |  | Oaktown Ave   |  | Baltimore Co. Md   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |   |                   | 25a. DATE REC'D. BY REGISTRAR   |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| Raymond J. Kozmowski  |  |   |                   | FEB 6 1984  |  |   |  | John J. Conner   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

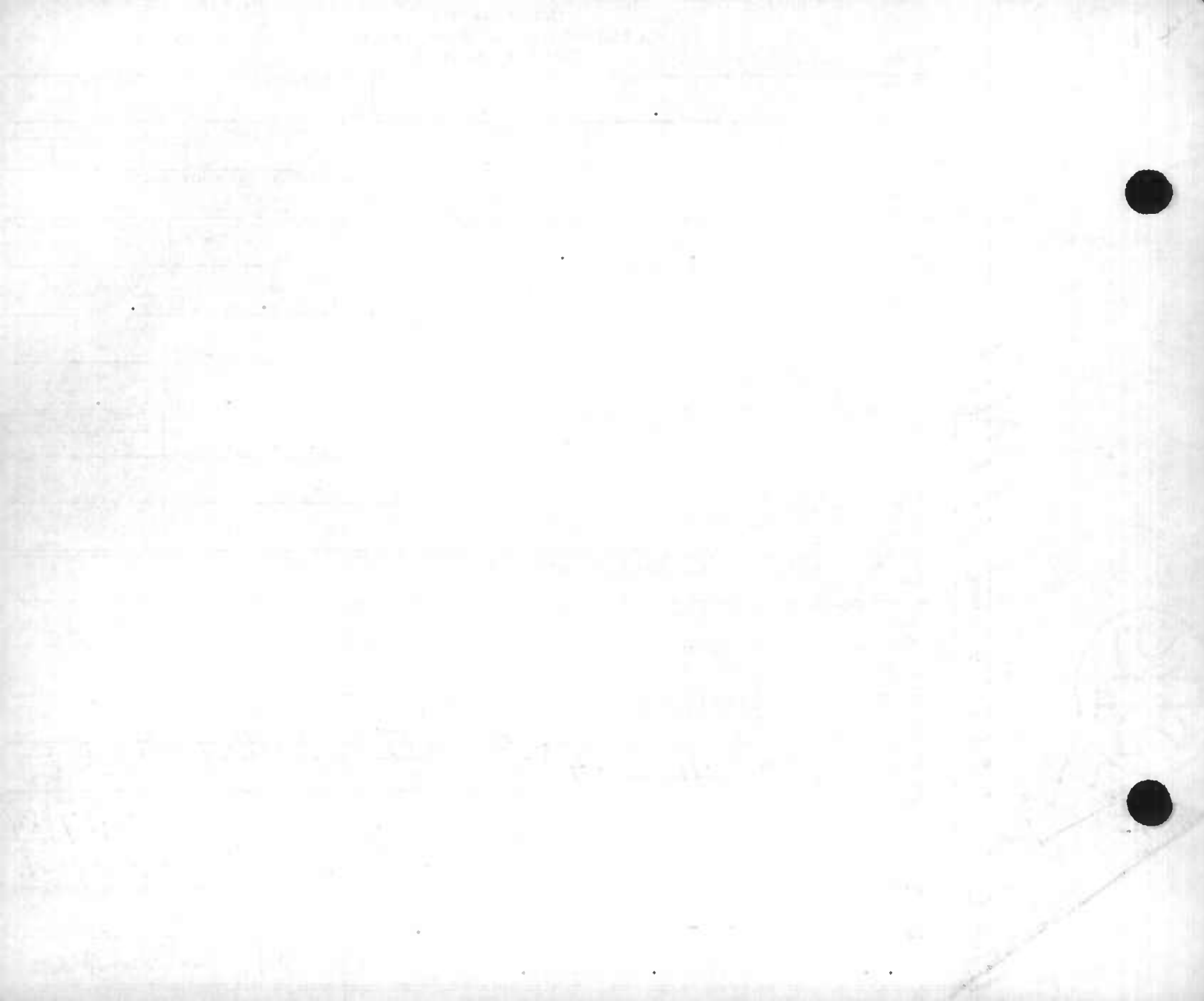




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |   |  |  |   |  |
|--|--|---|---|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | REG. NO. 04468  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) REBA C. SPANN   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR 2 10 84                  |  |  | 2b. HOUR M  |  |
| 3. SEX MALE  |  | 4. RACE BLACK   |   | 5. DATE OF BIRTH MONTH DAY YEAR 10 5 1909   |   | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS   |  | IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY? US   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD   |  |   |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1630 N. MONROE ST. |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC                       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |   |  |  |   |  |
| 13a. STATE MARYLAND  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN BALTIMORE   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 1630 N. MONROE ST. 21217  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUEMMA JACKSON |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS DEBORAH TALBOTT 1630 N. MONROE ST. 21217  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Small Cell Lung Cancer<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8.5 years |  |   |   |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 15, 1975, to Feb 10, 1984, that (I) (we) last saw the deceased alive on Feb 10, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |  |  |   |  |
| 22b. SIGNATURE E. W. Cole  |  |   |   |   | DEGREE  |  | 22c. DATE SIGNED 2/17/84                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE   |  |   |   |   | 22e. ADDRESS 51 Franklin St #420 Amaphd.                  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  |   | 23b. DATE 2-18-84   |   | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CENT.       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND |   |  |
| 24. FUNERAL DIRECTOR NAME E. L. PHILLIPS 1721 N. MONROE ST.  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR FEB 21 1984                 |  | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall           |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

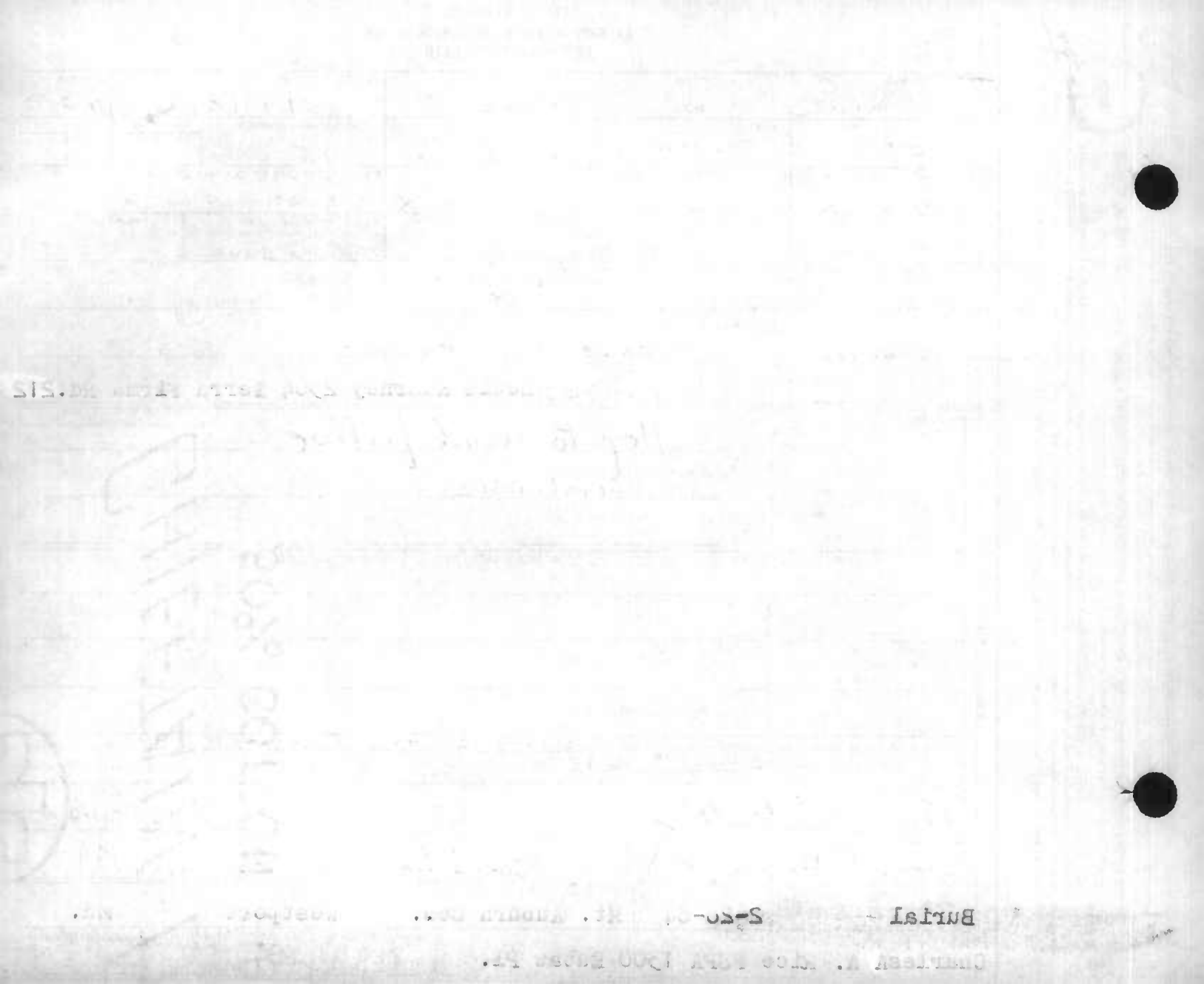
04469

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ALFRED W. SPENCE   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/19/84                         |   |   | 2b. HOUR<br>11:20 PM   |  |  |  |
| 3. SEX<br>♂   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 2 38  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>S. Balt. Gen. Hosp. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck driver   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>Balt. City  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>110 W. Hamburg St. 21230  |  |
| 14. FATHER'S NAME<br>FIRST MERVIN MIDDLE SPENCE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST CECILYDE MIDDLE PRICE LAST  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Unknown   |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-34-9465   |   | 17. INFORMANT<br>ADDRESS<br>Lewis Kearney 2504 Terra Firma Rd.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepato-renal failure<br>5715<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                    |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from February 2, 1984, to February 19, 1984, that (I) (we) lost<br>saw the deceased alive on February 19, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>James T. Heiser MD  |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2/20/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James T. Heiser M.D.   |  |  | 22e. ADDRESS<br>3001 S. Hanover Baltimore MD                           |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>2-28-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westport Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Charles A. Rice FSPA 1300 Eutaw Pl.  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 28 1984   |  |  |  |

MEDICAL CERTIFICATION

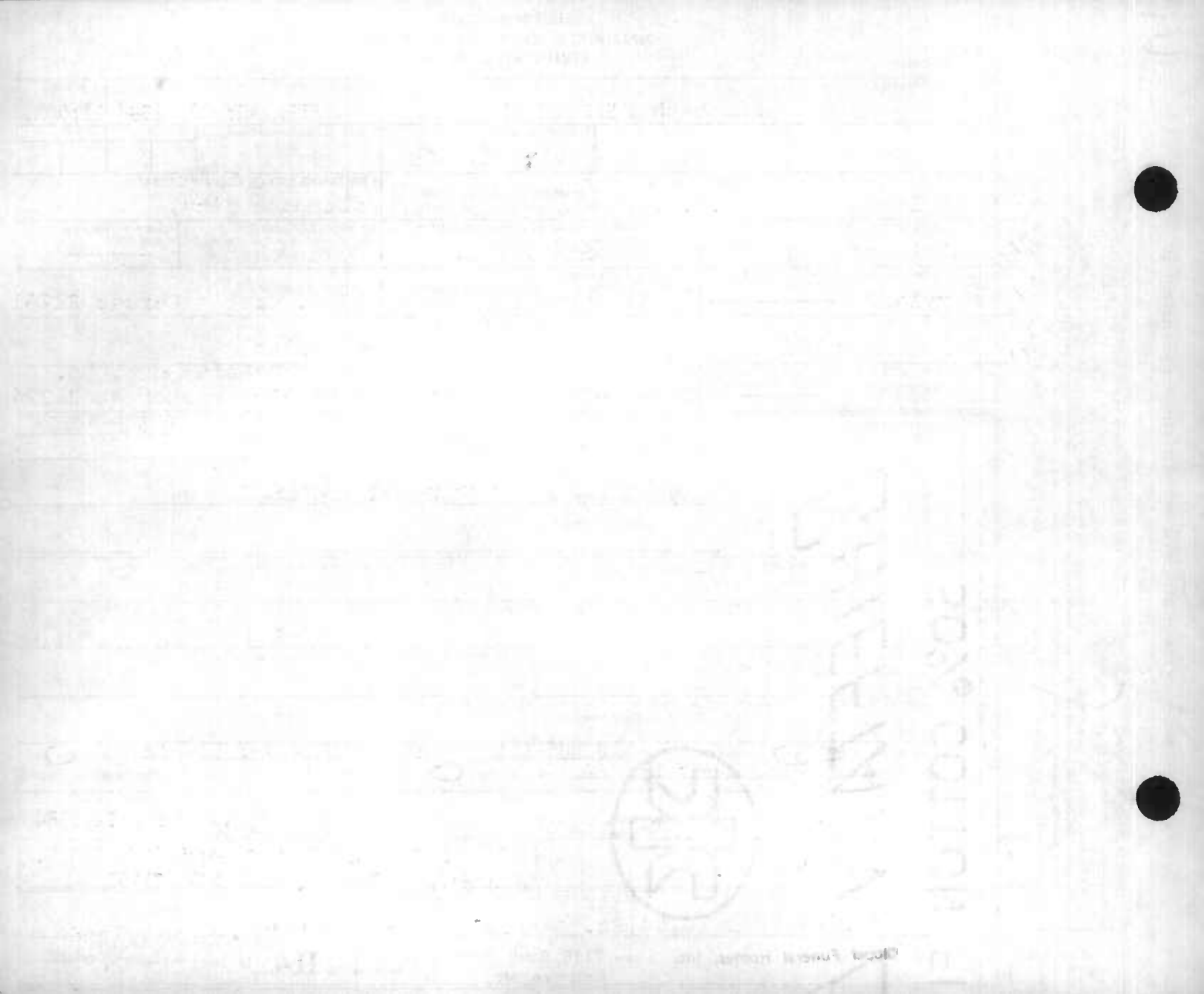


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO.<br>04470                            |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR<br>1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ANNA Elizabeth SPIESS  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEBRUARY 12, 1984  |  |  |  | 2b. HOUR<br>11:00A                           |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 21, 1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital, Inc. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home maker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>-----  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>18 S. Castle Street 21231   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Korycki  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Walas  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----  |  | 17. INFORMANT<br>ADDRESS<br>Baltimore, Md.  |  | 3705 Foster St 21224   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br><u>4360</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ACUTE STROKE WITH LEFT MEXXXX HEMIPLEGIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 30</u> 19 <u>84</u> , to <u>FEBRUARY 12</u> 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>FEBRUARY 12</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Mukesh Luhar MD</u>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>FEB 12, 1984   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MUKESH LUHAR, MD.  |  |   |  |   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Feb 16, 84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cem  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc.  |  |   |  |   |  | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 14 1984   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CUNY SPINELLA                       |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 17 84 |   |  | 2b. HOUR<br>4:50 P.M.                                  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 14 02   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ITALY                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, MD. |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERIDIAN NRSG. CTR.-HERITAGE |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Soap Mixer  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lever Bros.       |  |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Spinella                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Faranda  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>213-01-3006   |  | 17. INFORMANT ADDRESS<br>Mary Spinella 112 S. Highland Ave 21224  |  |  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Renal failure secondary to<br>arteriosclerotic cardiovascular<br>heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Congestive heart failure, Diabetes mellitus, organic brain   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1979, 19 to 19, that (I) (we) lost<br>saw the deceased alive on 2/16 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>A. F. Nour, M.D.  |  |  |  |  |  | 22c. DATE SIGNED<br>2/17/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. F. Nour, M.D.   |  |  |  | 22e. ADDRESS<br>121 South Highland Avenue, Balto.                                    |  |   |  |

|   |  |                      |  |   |  |   |  |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                              |  | 23b. DATE<br>2-20-84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>ZANNINO Funeral Home 263 South Conkling St. |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984              |  |   |  |
|   |  |                      |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson               |  |   |  |

Heart failure secondary to  
arteriosclerotic cardiovascular  
disease

Compensative heart failure, congestive edema, organic

A. J. K. R. P. 121 South Highland Avenue, Chicago, Ill.

121 South Highland Avenue, Chicago, Ill.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 04472  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 02-10-84   |  |   |  |
| 1 DECEASED NAME FIRST MIDDLE LAST MARY C. SPINASSO   |  |  |  | 2b. HOUR 6:15 PM  |  |   |  |
| 3 SEX Female   |  | 4 RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR 12-14-1895  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |  |
| 10 CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE Md.   |  |  |  | 13b. COUNTY Harford   |  | 13c. CITY OR TOWN Belcamp, Md.  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST John Sparago  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Camella  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |  |  | 16b. SOCIAL SECURITY NO. 217-32-8523 212-36-7078  |  | 17. INFORMANT ADDRESS Mrs. Rita Baran - 7026 Gough St. -21224   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) 4280 CARDIO Pulmonary Collapse<br>DUE TO, OR AS A CONSEQUENCE OF (b) CHF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |   |  |   |  |
| 22b. SIGNATURE X F W Schaefer MD Ph.D.   |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) X SCHAEFER   |  |  |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 2-13-84  |  | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.  |  |
| 24 FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR FEB 16 1984   |  | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell   |  |

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THE  
RELEASED AS NON MED BY DR THOMAS SMITH  
TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending MEDICAL EXAMINER'S OFFICE

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04473

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>NICHOLAS SPINOSO</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 26 1984</b>          |  | 2b. HOUR<br><b>01:05AM</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 12, 1983</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>3 14</b>                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Spinoso</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kathlyn Spinner</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>family</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>7684</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metabolic acidosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiopulmonary arrest</b>   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 minute</b><br><b>3 days</b><br><b>3 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Renal failure</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> 19 <b>84</b> to <b>2/26</b> 19 <b>84</b> , that (I) (we) saw the deceased alive on <b>2/26 10:5 AM</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Pamela J. Stone MD</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2/26/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Pamela J. Stone MD</b>  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>   |  | 23b. DATE<br><b>2/28/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's, Long Green Hyde Balto. MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Evans Chapel of Memories 8800 Harford Road</b>   |  | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1984</b>                                   |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>                             |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "1", the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04474

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SYLVIA SPIVACK   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/10/84 |   |  | 2b. HOUR<br>11:55 (P.M.)  |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 23, 1915   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 1 YEAR HOURS MIN.                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4212 LABYRINTH ROAD |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>29 WARREN PARK DR., APT. A2 #21208   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HYMAN BROTMAN   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH SCHNEIDERMAN  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>220-09-2578   |  | 17. INFORMANT<br>ADDRESS<br>#21208<br>JOSEPH SPIVACK 29 WARREN PARK DR., APT. A2   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic breast carcinoma</u><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>83</u> , to <u>2/10/84</u> , that (I) (we) last saw the deceased alive on <u>2/10/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Robert H. Gasson</u> MD.   |  |  |  | DEGREE<br>MD.   |  |   |  | 22c. DATE SIGNED<br>2/10/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEPHEN H. GASSON MD.  |  |  |  | 22e. ADDRESS<br>600 Reisterstown Rd. - Baltimore, Md.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>2-12-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SHOMREI HADATH VE TZEMECH   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 15 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                     |  |  |  |

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CONFIDENTIAL

TOP SECRET

CONFIDENTIAL

TOP SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, or medical event, must be indicated above.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |                                    |  |   |
|--|--|--|--|---|--|--|------------------------------------|--|---|
| FOR<br>1 - STATE REGISTRAR   |  |  |  |   |  |  |                                    |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John A Sprecher</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-17-84</b>                  |  |                                    |  |   |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 05 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS   |                                    | 7b. HOUR<br><b>8:45 A.M.</b>   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                                    |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Brewer-Carlings Brewery</b> |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                    | 13e. STREET ADDRESS<br><b>1100 Edmondson Avenue 21228</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Victor T. Sprecher</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Plowman</b> |  |                                    |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-8059</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Amelia Sprecher Same as # 13</b>  |  |  |                                    |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>4100 Congestive Cardiac Failure -</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anterior Septal Myocardial Infarction.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACVD.</b> |  |  |  |   |  |  |                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks.</b> |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Brain Stem Infarct.</b>   |  |  |  |   |  |  |                                    |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                    |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                    |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1984</b> to <b>Feb 17, 1984</b> , that (I) (we) lost <b>view the deceased alive on Feb 16, 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.  |  |  |  |   |  |  |                                    |  |   |
| 22b. SIGNATURE<br><b>Harry W. Knapp, MD.</b>   |  |  |  |   | DEGREE<br><b>MD.</b>   |  | 22c. DATE SIGNED<br><b>2-17-84</b> |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HARRY W. KNAPP, MD.</b>  |  |  |  |   | 22e. ADDRESS<br><b>5411 OLD FREDERICK Rd. BALTO, Md 21229</b>          |  |                                    |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/20/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Maryland</b>                                     |                                    |  |   |
| 24. FUNERAL DIRECTOR<br><b>Leboy, M. &amp; Russell C. Witzke Funeral Homes P.A.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1984</b>  |                                    |  |   |
| 1630 Edmondson Avenue, Catonsville, Maryland   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                                    |  |   |

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4.2.11

2452



REG. NO

|  |                                       |                               |                            |
|--|---------------------------------------|-------------------------------|----------------------------|
| 24. FUNERAL DIRECTOR<br>NAME           | SOL LEVINSON & BROS., INC.<br>ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 |                                       | FEB 24 1984                   | Davidson-Rendell           |

BP

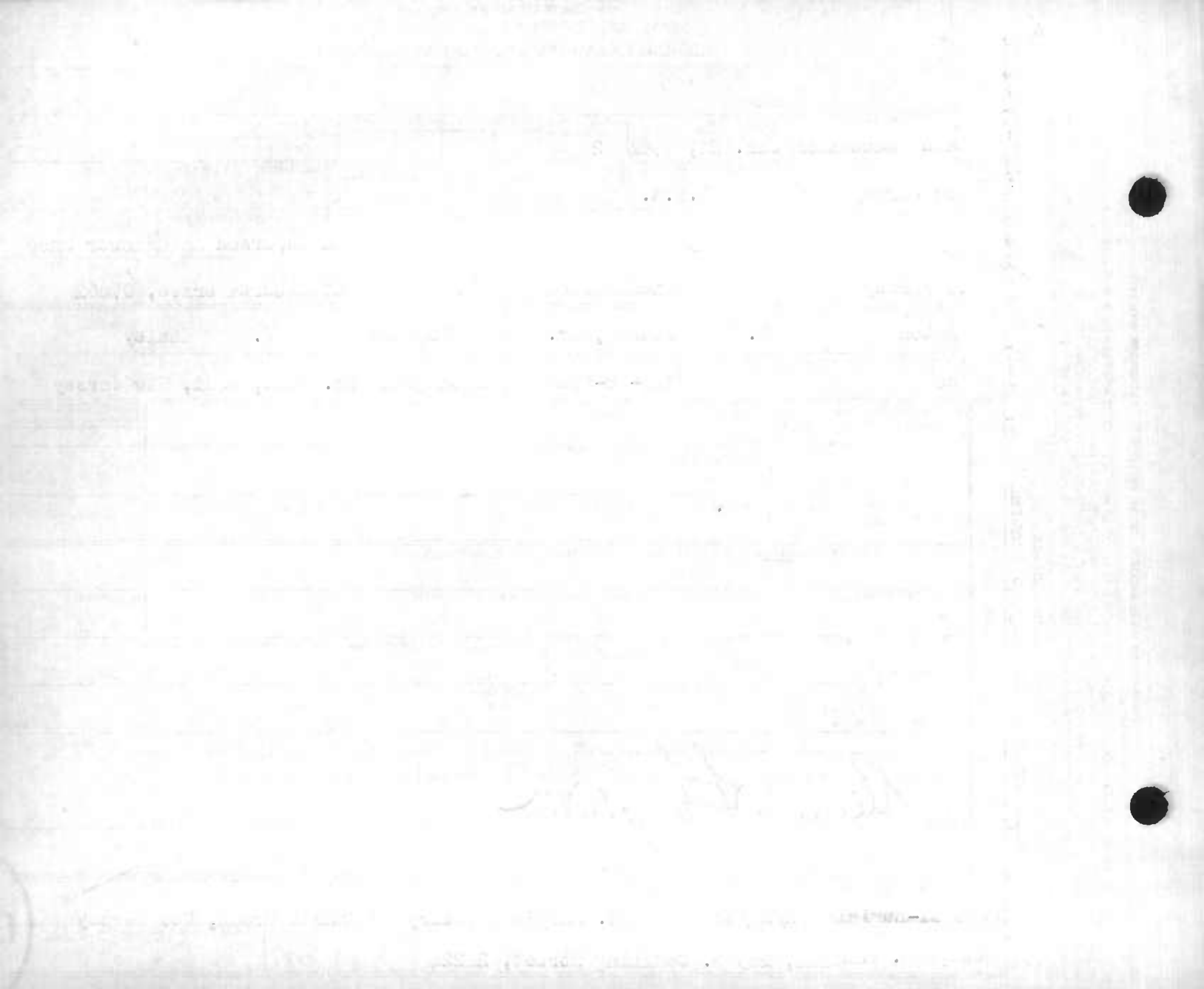
POST OFFICE  
CHIEF

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITHIN 72 HOURS, THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, MUST BE ADVISED BY TELEPHONE, MAIL, OR IN PERSON OF THE BURIAL, CREMATION, OR REMOVAL.

Transferred to Santangelo Funeral Home, Lodi, New Jersey 1-201-770-2386

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                             |   |  |  |   |   |   |  |  | REG. NO. 04477 |  |
|---|-----------------------------|---|--|--|---|---|---|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Michelle Stasny</b>  |                             |   |  |  |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR <b>2-19 1984</b>                                      |   | 2b. HOUR <b>M</b>                                  |  |                |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Jan. 21, 1964</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>20 YRS.</b>                        | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>2-19 1984</b>                                     |   | 2d. HOUR <b>12:34 a. M</b>                         |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |   |  |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Harbor Tunnel &amp; Moravia Road</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesperson</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Flower Shop</b>   |   |  |  |                |  |
| 13a. STATE<br><b>New Jersey</b>   |                             |   |  | 13b. COUNTY<br><b>Saddlebrook</b>  | 13c. CITY OR TOWN<br><b>Saddlebrook</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>61 Alberta Drive, 07662</b>                               |  |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anton W. Stasny, Jr.</b>   |                             |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia V. Hanley</b>   |   |   |   |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>  |                             |   |  | 16b. SOCIAL SECURITY NO.<br><b>149-66-6980</b>   |   | 17. INFORMANT ADDRESS<br><b>Santangelo Fun. Home, Lodi, New Jersey</b>                          |   |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cranio-cerebral Injury</b><br><b>8160</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                             |   |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                             |   |  |  |   |   |   |  |  |                |  |
| 19a. DATE OF OPERATION  |                             |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                          |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                             |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1222xx 2-19 1984</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>driver ejected from auto which overturned</b> |   |   |  |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                             |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Harbor Tunnel &amp; Moravia Rd., Balto., Maryland</b>                     |   |   |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                             |   |  |  |   |   |   |  |  |                |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth M.D.</i>   |                             |   | TITLE (SPECIFY)<br><b>M.D. Assistant</b>                                   |  |   | MEDICAL EXAMINER  |   |  | DATE SIGNED<br><b>2-19-84</b>                |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |                             |   | ADDRESS<br><b>111 Penn Street</b>  |  |   |   |   |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal-Burial</b>  |                             | 23b. DATE<br><b>2/23/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Saddle Brook, New Jersey</b>                   |   |  |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph N. Zannino</b>  |                             |   | ADDRESS<br><b>263 S. Conkling Street, 21224</b>                            |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John W. Smith</i> |  |                |  |



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DHMM - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 04478   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ESTELLE Przybyla-STAUFFER   |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEBRUARY 23, 1984   |  |  |  | 3b. HOUR<br>8:40 PM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 17, 1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | 8. UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE FULL ADDRESS)<br>Church Hosp. Inc |  |  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE WORK FOR MOST OF WORKING YR)<br>#                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4145 S. Joplin St 21224                                       |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>#   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Karoline May   |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>217-18-805   |  | 17. INFORMANT ADDRESS<br>Stephanie Zebrow 1202 Dubois Ave  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>2754<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>HYPOCALCEMIA ANEMIA HYPERTRODISM</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CARDIOVASCULAR DISEASE</u><br><del>EXAMINED BY MEDICATION REVIEW</del> |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB. 23</u> , 19 <u>84</u> , to <u>FEB. 23</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>FEB. 23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Mukesh Luear MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                |  |   |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MUKESH LUEAR MD   |  |  |  | 22e. ADDRESS<br>100 N. BROADWAY BALTO. MD 21231  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE)<br>Burial   |  |  |  | 23b. DATE<br>2-28-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview New Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                          |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Raymond J. Kozlowski  |  |  |  | 24b. ADDRESS<br>2525 Clark St.   |  | 25. DATE REC'D BY REGISTRAR<br>FEB 27 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall                                       |  |  |  |

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the structure of the atom is determined by the laws of quantum mechanics.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the structure of the atom is determined by the laws of quantum mechanics.

3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the structure of the atom is determined by the laws of quantum mechanics.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | REG. NO. 04479                               |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Morris I. Stein</i>   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>Feb 1 1984</i>   |  |  |  |  | 2b. HOUR <i>9:51</i> M                       |  |  |  |  |
| 3. SEX <i>MALE</i>  |  | 4. RACE <i>CAUCASIAN</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <i>6 17 09</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.                               |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital</i> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>BAKER</i>                   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>FOOD</i>  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <i>BALTO</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <i>6638 Vincent Ave</i>  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>BARNEY XXXXXXXXXXXXXXXXXXXX STEIN</i>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>KATE XXXXXXXXXXXXXXXXXXXX LOVE</i>   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>   |  | 16b. SOCIAL SECURITY NO. <i>212039964</i>  |  | 17. INFORMANT <i>SAMUEL STEIN</i> ADDRESS <i>APT. 2A 6968 BROOKMILL RD. BALTO., MD 21215</i>   |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Probable Myocardial Infarction</i><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Aseptic</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Choreoathetosis familiaris, small brainstem CVA</i>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>12/23/84</i> P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (H) (this hospital) attended the deceased from <i>2/1/84</i> 19 <i>84</i> , to <i>2/1/84</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>2/1/84</i> 19 <i>84</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <i>Vernon</i> DEGREE <i>MD</i>   |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED <i>2/1/84</i>   |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>VERNON</i>   |  |  |  |  | 22e. ADDRESS <i>3124 200 HOALEWOOD TERRACE</i>   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>   |  | 23b. DATE <i>FEB. 2, 1984</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>WORKMEN CIRCLE</i>   |  | 23d. LOCATION <i>BALTIMORE</i> <i>MARYLAND</i>   |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS., INC.</i> NAME ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>FEB 8 1984</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i> |  |  |  |  |  |  |  |

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|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|



Handwritten notes and markings, including the word "FIRE" and various symbols.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 689901   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>JOHN A. STERN  |  |   |  | 2a. DATE OF DEATH<br>2/27/84  |  | 2b. HOUR<br>10:30 AM   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>9 5 07  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LINEMAN             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>GAS & ELECTRIC CO.  |  |
| 13a. STATE<br>MD   |  |   |  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Balt.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>THEODORE  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FRANCES   |  | 16. STREET ADDRESS<br>2811 ASHLAND AVE. 21205  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>212-05-7433   |  | 17. INFORMANT<br>MARGARET BROWN (SISTER) SAME ADDRESS   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>4860 IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Pneumonia.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia.</u> |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>-  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> 19 <u>84</u> to <u>2/27</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>2/27</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>AGRAUSA L. Frankman  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>AGRAUSA L. Frankman   |  |   |  | 22e. ADDRESS<br>Lutheran Hosp.  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/3/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   |  | 23d. LOCATION<br>Baltimore, COUNTY MD. STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Schimunek Funeral Home, Inc.<br>ADDRESS 3331 Brehms Lane, Balto. Md. 21213  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                                  |  |  |  |

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

04482

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SARAH (SARA) STEWART</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>15</b> YEAR <b>84</b>  |   | 2b. HOUR<br><b>7:49</b> AM                       |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>20</b> YEAR <b>05</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                 |   | 7. UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore city</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES GENERAL HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Albert</b> MIDDLE <b>Stewart</b> LAST <b>Hackley</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Agnes</b> MIDDLE <b>Hackley</b> LAST <b>Hackley</b>  |   | 16. STREET ADDRESS<br><b>21201 124 W. Franklin St. Apt. 704</b>                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |   | 17. INFORMANT<br><b>Rev. A.L. Nichols</b> ADDRESS<br><b>Apt. J 3771 Brice Run Road</b>          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br><b>4039</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension, severe congestive heart failure</b> |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/14/84</b> to <b>2/15/84</b> , that (I) (we) last saw the deceased alive on <b>2/15/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Marcos B. Galicia Jr.</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>2/15/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARCOS B. GALICIA Jr.</b>   |   | 22e. ADDRESS  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |   | 23b. DATE<br><b>2/21/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co MD</b>  |   | 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>  |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Nordell</b>  |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10-11-1944

10-11-1944

10-11-1944

10-11-1944

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04483

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAX - Stichman</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>26</b> YEAR <b>1984</b> |   | 2b. HOUR<br><b>8:01 PM</b>   |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>caucasian</b>                  | 5. DATE OF BIRTH<br>MONTH <b>06</b> DAY <b>15</b> YEAR <b>1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN. |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LATVIA</b>  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b>                                      |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROPRIETOR</b>  |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  | 16. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 17. STREET ADDRESS / ZIP CODE <b>#21209</b><br><b>6154 GREENMEADOW PKWY</b>   |  |
| 18. FATHER'S NAME<br>FIRST <b>DESAH</b> MIDDLE <b>REMAN</b> LAST <b>STICHMAN</b>   |  | 19. MOTHER'S MAIDEN NAME<br>FIRST <b>BLUMA</b> MIDDLE <b>ETHEL</b> LAST <b>UNKNOWN</b>  |  |   |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b> <b>WWI-ARMY</b>   |  | 21. SOCIAL SECURITY NO.<br><b>216-32-7767</b>   |  | 22. INFORMANT<br><b>ESTATE OF THE LATE MAX STICHMAN</b><br><b>C/O J. MAYER WILLEN P.O. BOX 21484</b><br><b>3410 OLD POST DR. BALTO., MD 21208</b> |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |   |  |   |  |
| 24. DATE OF OPERATION<br><b>2/26</b>   |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 28. TIME OF INJURY<br>HOUR <b>19</b> A.M. MONTH <b>2</b> DAY <b>26</b> YEAR <b>1984</b>   |  | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 30. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 31. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 32. LOCATION<br>STREET <b>Belvedere &amp; Greenspring</b> CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MD</b>                    |  |
| 33. I certify that (I) (this hospital) attended the deceased from <b>2/26</b> , 19 <b>84</b> , to <b>2/26</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2/26</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |   |  |   |  |
| 34. SIGNATURE<br><b>John Ford</b>  |  | 35. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                |  | 36. DATE SIGNED<br><b>2/26/84</b>   |  |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Ford</b>   |  | 38. ADDRESS<br><b>Belvedere &amp; Greenspring</b>   |  |   |  |
| 39. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 40. DATE<br><b>2/29/84</b>  |  | 41. NAME OF CEMETERY OR CREMATORY<br><b>SHAAREI ZION CEM.</b>   |  |
| 42. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  | 43. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1984</b>   |  | 44. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodase</b>   |  |
| 45. NAME<br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>   |  | 46. ADDRESS   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, a medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and completely filled in by the attending physician and completely filled in by the funeral director. Page 1 and 2 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 and 2 should be detached for use as the death certificate. Page 3 should be detached for use as the death certificate. Page 4 should be detached for use as the death certificate. Page 5 should be detached for use as the death certificate. Page 6 should be detached for use as the death certificate. Page 7 should be detached for use as the death certificate. Page 8 should be detached for use as the death certificate. Page 9 should be detached for use as the death certificate. Page 10 should be detached for use as the death certificate. Page 11 should be detached for use as the death certificate. Page 12 should be detached for use as the death certificate. Page 13 should be detached for use as the death certificate. Page 14 should be detached for use as the death certificate. Page 15 should be detached for use as the death certificate. 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Page 96 should be detached for use as the death certificate. Page 97 should be detached for use as the death certificate. Page 98 should be detached for use as the death certificate. Page 99 should be detached for use as the death certificate. Page 100 should be detached for use as the death certificate.

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DHMH - 16 50M 4/83  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THOMAS B. STILL</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 2, 1984</b> |   |  | 2b. HOUR<br><b>4:35 M</b>  |  |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/7/16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMP</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MD</b>  |  | 13c. COUNTY<br><b>BALTO</b>  |  | 13d. CITY OR TOWN<br><b>ESSEX</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>555A S. MARLYN 21221</b>                        |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>VAN BUREN STILL</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SALLIE MAE REARDEN</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>249 071166</b>  |  | 17. INFORMANT<br><b>EULA STILL</b>  |  | ADDRESS<br><b>ABOVE</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991 IMMEDIATE CAUSE (a) Cardio-respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastatic carcinoma</b>   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>12</b><br><b>imo.</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>none</b>   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/31/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Obstructive jaundice</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/20</b> , 19 <b>83</b> , to <b>2/2</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>M. R. L. He MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>2/2/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. R. L. He</b>  |  |  |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL<br/>500 N. WOLFE ST. BALTO. 21205, MD.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>REMOVAL - BURIAL</b>  |  | 23b. DATE<br><b>2/6/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GLENVIEW CEM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>EDGEFIELD S.C.</b>                  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. G. CONNELLY</b>  |  |  |  | ADDRESS<br><b>300 MACE</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 7 1984</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in the office of the Registrar, it should be detached for use as the burial-transit permit. Then please remove carbon papers. If the deceased was a member of the armed forces, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |   |  |   |  |
|---|--|---|--|---|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | (BESSIE)  |  |   |   | REG. NO.  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELIZABETH MARIE STINCHCOMB   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 19, 1984                      |   |   | 2b. HOUR<br>A<br>12:50 <sub>M</sub>  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 31, 1911  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                              |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Sales Clerk |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hutzi's - Dept. Store   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   |  |   | 13b. COUNTY<br>Howard   |   | 13c. CITY OR TOWN<br>Columbia                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Winfield Shriver  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura May Steinford          |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>213-20-0825   |  | 17. INFORMANT<br>Mrs. Jane Allen  |   | ADDRESS 3228 Woodstream Lane<br>Ellicott City, Md. 21043                                |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary Artery Disease</u> |  |   |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs<br>12 hrs                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>84</u> , to <u>2/18</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2/18</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>William G. Kaelin Jr.</u>  |  |   |  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>2/18/84                                 |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM G. Kaelin Jr.                                  |  |
| 22e. ADDRESS<br>600 N. WOLFE ST. - BALTO. MD.<br>Johns Hopkins Hospital   |  |   |  |   | 22f. ADDRESS<br>21205   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>2/21/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984                                  |   |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Jana Harrison-Randall   |  |   |  |   |   |   |   |  |   |  |

MEDICAL CERTIFICATION

666

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner may be notified in advance.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 04486<br>REG. NO.   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Martha A. (Stinnett)</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>20</b> YEAR <b>84</b>  |  | 2b. HOUR<br><b>M</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>21</b> YEAR <b>89</b>  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY) <b>94</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>516 N. Arlington Ave.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a. STATE <b>Maryland</b>  |  |   |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Brown</b> LAST <b>Brown</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Amelia</b> MIDDLE <b>Amelia</b> LAST <b>Amelia</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-76-2481</b>  |  | 17. INFORMANT<br><b>Hazel F. Stinnett</b> ADDRESS <b>516 N. Arlington Ave.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b><br>IMMEDIATE CAUSE (a) <b>Poison shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Poison myocardial infarct</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b> |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>R. Sabundayo</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>2/22/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rolendo M. Sabundayo</b>  |  |   |  | 22e. ADDRESS<br><b>1940 W. Baltimore St.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>2/25/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Md.</b> COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b> 25b. REGISTRAR'S SIGNATURE <b>J. Harrison</b>  |  |   |  |

LIBER

NOV 10 1890

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NOV 10 1890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director's office. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR Item #5 film #G589  
1- STATE REGISTRAR 3/15/84 jp

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04487

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <i>Marie</i> MIDDLE <i>Stinson</i> LAST <i>Stinson</i>   |  |   | 2a. DATE OF DEATH<br>MONTH <i>2</i> DAY <i>1</i> YEAR <i>84</i> 2b. HOUR <i>6:30 A</i> M. |   |  |
| 3. SEX<br><i>F</i>  |  | 4. RACE<br><i>Cau</i>   |   | 5. DATE OF BIRTH<br>MONTH <i>10</i> DAY <i>8</i> YEAR <i>98</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Utah</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>88</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Edgewood Nursing Home</i> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.   |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Maryland</i> 13b. COUNTY <i>Balto.</i>  |  | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>housewife</i>   |   | 12c. KIND OF BUSINESS OR INDUSTRY<br><i>homemaking</i>  |  |
| 14. FATHER'S NAME<br>FIRST <i>Emil</i> MIDDLE <i>Sager</i> LAST <i>Sager</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Elizabeth</i> MIDDLE <i>Kelly</i> LAST <i>Kelly</i>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>215-48-7133</i>  |   | 17. INFORMANT ADDRESS<br><i>7 Bonton Ct. Maxine M. Shanklin Balto., Md. 21136</i>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>MYOCARDIAL ISCHEMIA</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>MYOCARDIAL INFARCTIONS -</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>ASCVD</i> |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/21/84</i> to <i>2/21/84</i> , that (I) (we) lost <i>9/21/83</i> <i>2/21/84</i> <i>1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><i>Anthony F Carozza MD</i> DEGREE <i>MD</i>  |  |   |   | 22c. DATE SIGNED<br><i>2/2/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Anthony F CAROZZA</i>   |  |   |   | 22e. ADDRESS<br><i>6000 BELLENA AVE BALTO MD 21212</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>2-4-84</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood Cemetery</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Lassah FH</i> 7901 Belair Rd  |  | 23d. LOCATION<br>CITY OR TOWN <i>Baltimore</i> COUNTY <i>Maryland</i> STATE   |   | 25a. DATE REC'D. BY REGISTRAR <i>FEB 9 1984</i> 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>          |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Other," the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO. 04788

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM C STOREY   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 29 84                                  |  | 2b. HOUR<br>10:05 PM   |
| 3 SEX<br>Male  | 4 RACE<br>White  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>1 6 20  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Alabama   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC 3900 LOCH RAVEN BLVD 21218 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machinist   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction                                    |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>412 Park Ave. 21201  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Storey   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Whitier                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII  | 17. INFORMANT<br>ADDRESS<br>Mrs. Anna L. Storey Belmont, N.C. Georgiabelle Ave. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio respiratory arrest</u><br>4280 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>congestive heart failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>months  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (X) (this hospital) attended the deceased from FEBRUARY 8, 1984, to FEBRUARY 29, 1984, (we) lost saw the deceased alive on FEBRUARY 29, 1984, and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.   |  |  |   |  |  |
| 22b. SIGNATURE<br>J. Reilly MD<br>J. Reilly MD   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |   | 22c. DATE SIGNED<br>3/1/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD 21218   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  | 23b. DATE<br>3/1/84  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  | ADDRESS<br>Balto., Md.   |   | FEB 05 1984 J. A. Davidson Registrar   |  |

BP



*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



FEB 03 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Frederick ----- Strobel   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-23-84 |   |  | 2b. HOUR<br>2:57 AM   |  |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-25-01  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machinist                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Balto. Md. 21230<br>1711 Byrd ST. 21230 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William ----- Strobel  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth ----- Nugei  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                       |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-01-1494  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Mildred L. Strobel, Same as above                              |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinoma of the lung

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Gastric Ulcers

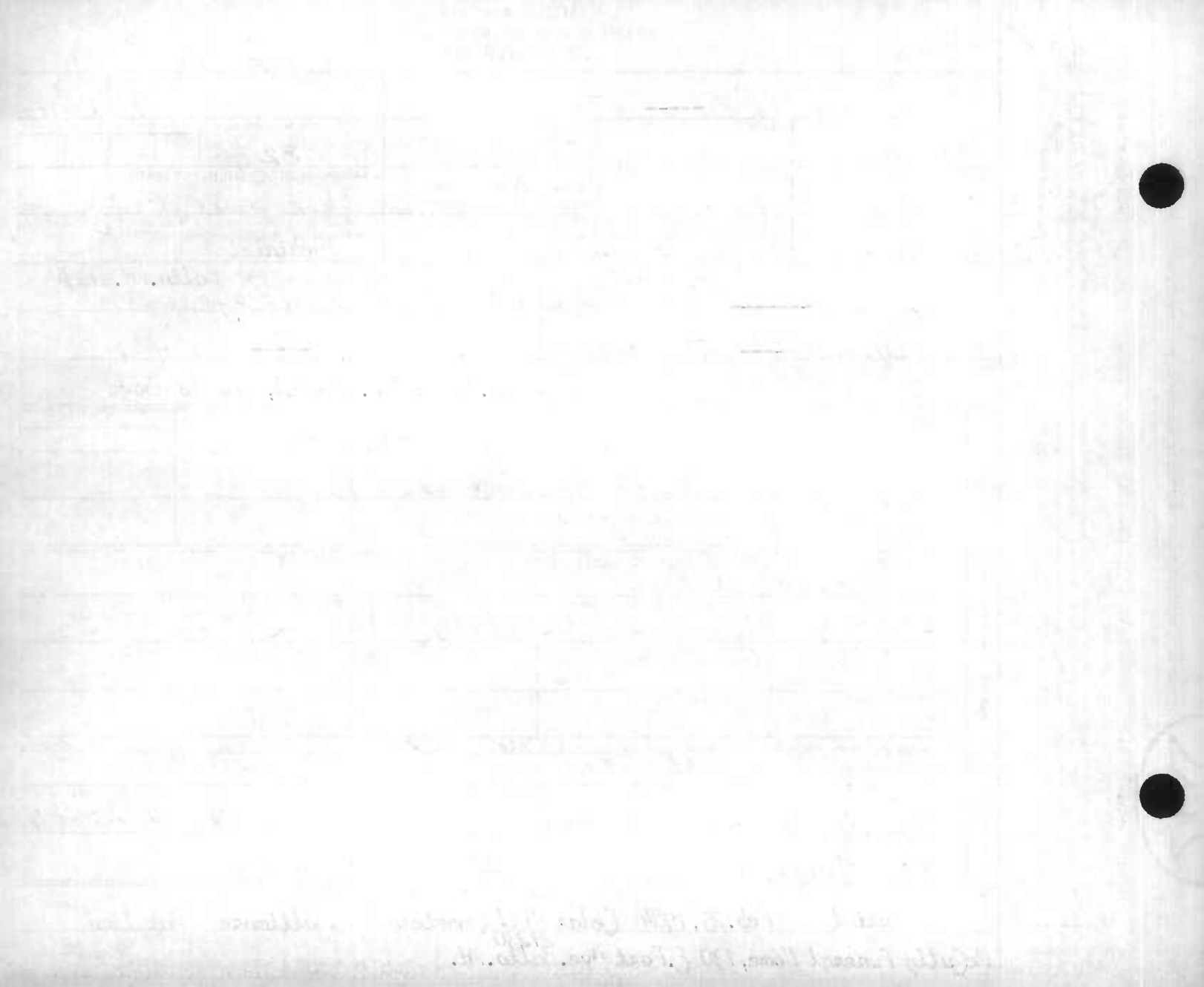
|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION<br>2-3-84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma Resection |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-16, 1984, to 2-23, 1984, that (I) (we) last saw the deceased alive on 2-23, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Rhonda G. Richards M.D.  |  |   |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>2-23-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Howard  |  |   |  | 22e. ADDRESS<br>3001 S. Hanover  |  |  |  |

|   |  |                            |  |   |  |  |  |
|---|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                    |  | 23b. DATE<br>Feb. 25, 1984 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>McCully Funeral Home, 130 E. Fort Ave. Balto. Md. |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1984              |  | 25b. REGISTRAR'S SIGNATURE<br>Lia Davidson-Randall               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04490

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                           |   |   |
|---|--|---|--|---|---------------------------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Lillie W. Strothe</u>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>Feb. 21, 1984</u> |   | 2b. HOUR<br><u>7 A.M.</u> |   |   |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>Black</u>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>March 12, 1899</u>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>84 Y.O.</u>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>CANVILLE-VA</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>AMERICA</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><u>BALTO. MD</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>KENSON NURSING HOME</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>TEACHER (Ret)</u>  |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>School City</u>   |   |
| 13a. STATE<br><u>Maryland</u>   |  | 13b. COUNTY<br><u>Baltimore</u>   |  | 13c. CITY OR TOWN<br><u>Baltimore</u>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Dolphus Wilson</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Jane Wilson</u>   |  | 13e. STREET ADDRESS<br><u>701 N. Glover Street</u>  |                           | 13f. CITY OR TOWN<br><u>Baltimore, Maryland 21205</u>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>214-40-8303</u>  |  | 17. INFORMANT<br><u>Vivian L. Smith</u>   |                           | ADDRESS<br><u>12 Winters Lane</u><br><u>Baltimore, Maryland 21228</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Brain Stem Stroke</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Emboli of deep vein thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Generalized Arteriosclerosis</u>  |  |   |  |   |                           |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Aspiration pneumonia. Senile Dementia</u>  |  |   |  |   |                           |   |   |
| 19a. DATE OF OPERATION<br><u>—</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>—</u>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br><u>N/A</u>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>N/A</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>N/A</u>  |                           |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/><br><u>N/A</u>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>N/A</u>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>N/A</u>   |                           |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> , 19 <u>83</u> , to <u>2/21</u> , 19 <u>84</u> , that (I) <u>was</u> last<br>saw the deceased alive on <u>2/16</u> , 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <u>did</u> <u>(did not)</u> view the body after death. |  |   |  |   |                           |   |   |
| 22b. SIGNATURE<br><u>Schue-Yuan Liao, M.D.</u>  |  |   |  | DEGREE<br><u>—</u>  |                           | 22c. DATE SIGNED<br><u>2/21/84</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Schue-Yuan Liao, M.D.</u>   |  |   |  | 22e. ADDRESS<br><u>Rm 215, Osler Medical Center</u><br><u>7600 Osler Dr. Towson, Md. 21204</u>  |                           |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>2/24/1984</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>  |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Md.</u>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Nutter &amp; Sons Funeral Home Inc.</u>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 23 1984</u>   |                           | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |   |
| 2501 Gwynns Falls Parkway Baltimore, Md. 21216  |  |   |  |   |                           |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified at once.

BP

Balto.  
City  
12 Winters Lane  
Baltimore, Maryland 21228

X Baltimore

Maryland

Wilson  
12 Winters Lane  
Baltimore, Maryland 21228

on

Delmar

Burial  
Nutter & Sons Funeral Home Inc.  
2734/198 Cedar Hill Cemetery

1501 Gwynns Falls Parkway Baltimore, Md. 21216

Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |                       | 04491  |  |
|---|--|---|--|---|--|--|--|--|-----------------------|--|--|
| 1- FOR STATE REGISTRAR MYRTLE MATILDA STRUMKE   |  |   |  |   |  |  |  |  |                       | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MYRTLE MATILDA STRUMKE   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEBRUARY 17, 1984  |  |  | 2b. HOUR<br>7:38 P.M. |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11/23/1903   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |                       | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITALS |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SWITCHBOARD OPER.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BROKERAGE                                       |                       |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>-----  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>6528 COLGATE AVENUE 21222                          |                       |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WILLIAM CHRISTIAN STRUMKE  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>DORA FOLTZ   |  |  |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br>215.05.2734   |  | 17. INFORMANT<br>JOHN P. HAHN  |  | ADDRESS<br>10018 WATERFORD DRIVE<br>ELLICOTT CITY, MD. 21043                         |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pneumonia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chemo-vascular accident</u>                         |  |   |  |   |  |  |  |  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>2 weeks</u>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |   |  |   |  |  |  |  |                       |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                       |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>January 30</u> , 19 <u>84</u> , to <u>FEBRUARY 17</u> , 19 <u>84</u> , that <del>he</del> (we) last saw the deceased alive on <u>FEBRUARY 17</u> , 19 <u>84</u> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>did not</del> view the body after death. |  |   |  |   |  |  |  |  |                       |  |  |
| 22b. SIGNATURE<br><u>Dr. Thomas M.D.</u>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>FEB. 17, 1984</u>   |                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MICHAEL J. MININSON, M.D.</u>   |  |   |  |   |  | 22e. ADDRESS<br><u>BALTIMORE CITY HOSPITAL, BALTIMORE, MD - 21204</u>  |  |  |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |   |  | 23b. DATE<br>2/20/1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                     |                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                          |                       |  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GEORGE T. STURGIS</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 / 4 / 84</b>   |  | 2b. HOUR<br><b>2:00 AM</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 / 3 / 19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>64</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>- - -</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>- - -</b>   |  | 13e. STREET ADDRESS<br><b>630 N. Denison St. 21229</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES  |  | 16b. SOCIAL SECURITY NO.<br><b>218-10-0576</b>   |  | 17. INFORMANT ADDRESS<br><b>Apt. 3D Thomas Sturgis 7400 Fairbrook Road</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5860 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>UREMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5860</b>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Pulmonary embolism; pulmonary edema; colitis</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/1/84</b> 19 <b>83</b> to <b>2/4</b> 19 <b>84</b> that (I) (we) last saw the deceased alive on <b>2/4</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>L. C. Cuen</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>2/4/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LEDICINA L. CUEN</b>   |  | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/8/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>   |  | 23d. LOCATION CITY COUNTY STATE<br><b>Crownsville Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C. March Funeral Home</b>   |  | ADDRESS<br><b>1101 E. North Ave</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 7 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04493

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                              |  |  |
|---|--|---|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Mary M. Sullivan</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>2-18-1984</i> |   | 2b. HOUR<br><i>7:30 P.M.</i> |  |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2-17-1908</i>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><i>76</i>          |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)<br><i>Ind.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baeth City</i> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1447 Washington Blvd. 21230</i> |   | 12. USUAL OCCUPATION<br>(SPECIAL WORK FOR MOST OF WORKING LIFE)<br><i>Waitress</i>  |                              | 13. KIND OF BUSINESS OR INDUSTRY<br><i>Restaurant</i>                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>Ind.</i> |  | 13b. COUNTY<br><i>Baeth</i>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              | 13d. STREET ADDRESS / ZIP CODE<br><i>1447 Washington Blvd. 21230</i>       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph Chaffman</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Pheresa Rincannon</i>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><i>No</i>  |                              | 17. INFORMANT<br>ADDRESS<br><i>Doris Veneziano 4404 LaPlata Ave. 21211</i> |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> years<br><i>2500</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <i>+ Multiple Myeloma</i> years |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *a*

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>AUG 16</i> , 19 <i>74</i> , to <i>Feb 8</i> , 19 <i>84</i> , that (I) <i>(was)</i> last saw the deceased alive on <i>Feb 8</i> , 19 <i>84</i> , and that in <i>(my)</i> <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(If the doctor did not see the body after death.)</i> |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>2/20/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>H.C. ALKIVIZATIS MD</i>  |  |  |  | 22e. ADDRESS<br><i>307 47 Paul Place Baeth Md</i>  |  |  |  |

|  |  |                               |  |  |  |  |  |
|--|--|-------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                |  | 23b. DATE<br><i>2-22-1984</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Cem. Woodlawn Baeth Co. Ind.</i>         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>John J. Cowen, Sr. 901 Hollins St. Baeth Ind.</i> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><i>FEB-22 1984 [Signature]</i> |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

RECEIVED

RECEIVED

FEB 23 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR AT 5 ME (5))  
20M, 4/82

FOR  
- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                         |                        |  |  |   |  |   |                                |  |  |  |  |   |                            |  |  |  |  |  |  |  |  |
|--|--|-------------------------|------------------------|--|--|---|--|---|--------------------------------|--|--|--|--|---|----------------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                         | FIRST<br><b>THOMAS</b> |  |  | MIDDLE<br><b>James</b>                            |  |   | LAST<br><b>SUMMERVILLE Jr.</b> |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2 6 1984 |  |   | 2b. HOUR<br>M<br>4:37 P.M. |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 2 1929</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>2 8</b>   |                                | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>19 84</b> |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2 8 19 84</b>                 |  |   | 2d. HOUR<br>M<br>4:37 P.M. |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |  |   |                            |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3208 Yosemite Ave.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Vice Principal</b>  |                                |  |  | 12b. KIND OF BUSINESS<br><b>Armstead Garden School</b>                         |  |   |                            |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |                        | 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |                                |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |   |                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br><b>3208 Yosemite Avenue</b><br><b>Baltimore, Maryland 21215</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas J. Summerville Sr.</b>   |  |                         |                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Etta Johnson</b>   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                                |  |  | 16b. SOCIAL SECURITY NO.<br><b>231-20-9105</b>                                 |  |   |                            | 17. INFORMANT<br><b>Margaret W. Summerville</b>  |  |  |  | ADDRESS<br><b>3208 Yosemite Ave Balto. Md. 21215</b>                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive &amp; arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>(c) _____   |  |                         |                        |  |  |   |  |   |                                |  |  |  |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |                         |                        |  |  |   |  |   |                                |  |  |  |  |   |                            |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                                |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                |  |  |  |  |   |                            |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                         |                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |  |  |  |  |   |                            |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |                        |  |  |   |  |   |                                |  |  |  |  |   |                            |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>   |  |                         |                        | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br><b>2-9-84</b>  |                                |  |  |  |  |   |                            |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Daxon, M.D.</b>   |  |                         |                        | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>  |  |   |  |   |                                |  |  |  |  |   |                            |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |                        | 23b. DATE<br><b>2/14/1984</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Veterans</b>   |                                |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>       |  |   |                            |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nutter &amp; Sons</b>   |  |                         |                        | ADDRESS<br><b>2501 Gwynns Falls Pkwy.</b>  |  |   |  | DATE REC'D. BY REGISTRAR<br><b>FEF 1 4 1984</b>   |                                |  |  | 25. REGISTRAR'S SIGNATURE<br>  |  |   |                            |  |  |  |  |  |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04495

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |   |  |  |  |
|---|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lelia Booker Sumpter</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/2/84</b>                          |  |  | 2b. HOUR<br><b>15<sup>30</sup> M</b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 26, 1888</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS.                                |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Keswick Home</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Health Care</b>  |  |  |
| 13a. STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>700 W. 40th Street 21211</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Sumpter</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hennriane Booker</b>   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>225 10 8322</b> |  | 17. INFORMANT<br><b>Grace Mc Faul</b>  |  | ADDRESS<br><b>542 W. University Parkway</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerotic Cerebrovascular Disease</b><br><b>4370</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs.</b> |  |  |   |  |  |  |   |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 July</b> 19 <b>76</b> to <b>2 Feb</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2 Feb</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.   |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Deborah D. R. [Signature]</b>  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2 Feb 1984</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  | 22e. ADDRESS   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY <b>Burial</b>  |  |  | 23b. DATE<br><b>2/4/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Balto. Co. Md.</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home, 3631 Falls Road 21211</b>   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25% COTTON



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

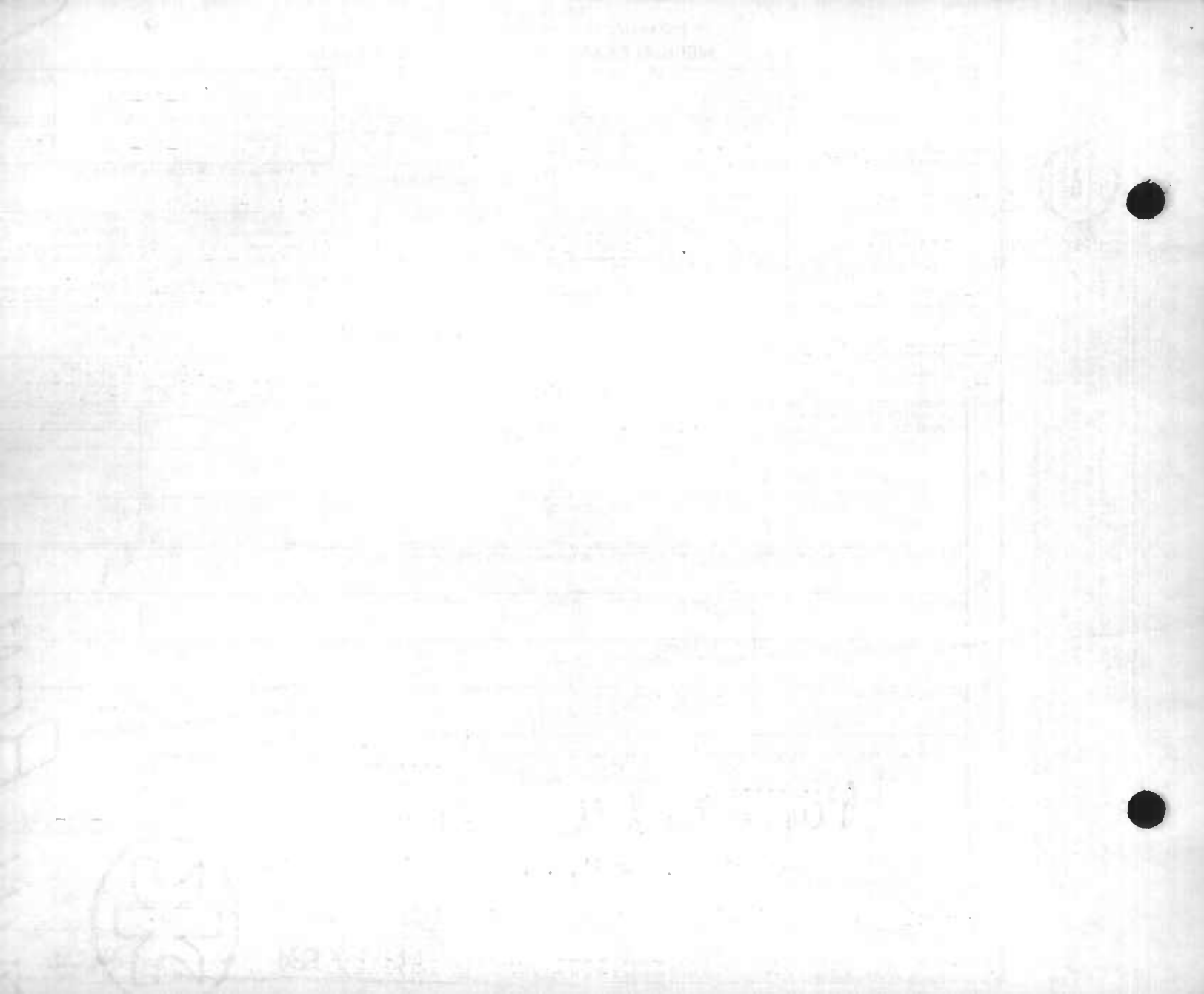
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |        |  |   |  |   |  |  |  |                               |  |   |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|---|--|--------|--|---|--|---|--|--|--|-------------------------------|--|---|--|----------|--|--|--|----------------|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |        |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH       |  |   |  |          |  |  |  |                |  | 2b. HOUR                   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |        |  |   |  |   |  |  |  | 2c. DATE ESTIMATED            |  |   |  |          |  |  |  |                |  | 2d. HOUR                   |  |  |  |  |  |  |  |  |  |
| ELIZABETH SUTTON  |  |        |  |   |  |   |  |  |  | 1-31-84                       |  |   |  |          |  |  |  |                |  | 11AM                       |  |  |  |  |  |  |  |  |  |
| 3 SEX   |  | 4 RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.              |  | 7c. DATE PRONOUNCED DEAD  |  | 7d. HOUR |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| Female  |  | Cauc.  |  | 4/3/21  |  | 62 YRS  |  | MONTHS   |  | DAYS                          |  | HOURS   |  | MIN.     |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |        |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |          |  | 10. CITY OR TOWN OF DEATH                    |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| Maryland  |  |        |  | USA   |  |   |  |  |  |                               |  | Baltimore City  |  |          |  | Baltimore                                    |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                               |  | 13a. STATE  |  |          |  | 13b. COUNTY                                  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| 2817 N. Calvert Street  |  |        |  | Waitress  |  |   |  | Restaurant   |  |                               |  | Maryland  |  |          |  | -  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| 13c. CITY OR TOWN   |  |        |  | 13d. INSIDE CITY LIMITS?  |  |   |  | 13e. STREET ADDRESS  |  |                               |  | 14. FATHER'S NAME   |  |          |  | 15. MOTHER'S MAIDEN NAME                     |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| Baltimore   |  |        |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  | 2817 N. Calvert St. 21218  |  |                               |  | Thomas J. Sutton  |  |          |  | Loretta Miller                               |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |        |  | 16b. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT  |  |                               |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)     |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| No  |  |        |  | 214-14-8980   |  |   |  | Robert Sutton, 301 Heming Way 21014  |  |                               |  | PART 1 DEATH WAS CAUSED BY:   |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |        |  |   |  |   |  |  |  |                               |  | IMMEDIATE CAUSE (a) Cirrhosis of Liver  |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |        |  |   |  |   |  |  |  |                               |  | 5715  |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |        |  |   |  |   |  |  |  |                               |  | DUE TO, OR AS A CONSEQUENCE OF  |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |        |  |   |  |   |  |  |  |                               |  | (b)   |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |        |  |   |  |   |  |  |  |                               |  | DUE TO, OR AS A CONSEQUENCE OF  |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |        |  |   |  |   |  |  |  |                               |  | (c)   |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |        |  |   |  |   |  |  |  |                               |  |   |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |        |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |                               |  | 20. AUTOPSY?  |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |        |  |   |  |   |  |  |  |                               |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |        |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  |  |  |                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |        |  |   |  | P.M. 19   |  |  |  |                               |  |   |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |        |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |  |                               |  | 21f. LOCATION   |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |        |  |   |  |   |  |  |  |                               |  | CITY OR TOWN COUNTY STATE   |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |        |  |   |  |   |  |  |  |                               |  |   |  |          |  |  |  |                |  |                            |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |        |  |   |  |   |  |  |  | TITLE (SPECIFY)               |  |   |  |          |  |  |  |                |  | DATE SIGNED                |  |  |  |  |  |  |  |  |  |
| Margarita A. Korell, M.D.   |  |        |  |   |  |   |  |  |  | Assistant                     |  |   |  |          |  |  |  |                |  | 2-12-84                    |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |        |  |   |  |   |  |  |  | ADDRESS                       |  |   |  |          |  |  |  |                |  | 111 Penn Street            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |        |  |   |  | 23b. DATE   |  |  |  |                               |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |          |  |  |  | 23d. LOCATION  |  |                            |  |  |  |  |  |  |  |  |  |
| Burial  |  |        |  |   |  | 2/14/84   |  |  |  |                               |  | Gardens of Faith  |  |          |  |  |  | Baltimore, Md. |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |        |  |   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR |  |   |  |          |  |  |  |                |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |  |  |  |  |
| SCHIMUNEK FUNERAL HOME, INC, 3331 Brehms  |  |        |  |   |  |   |  |  |  | FEB 17 1984                   |  |   |  |          |  |  |  |                |  | Julia Davidson-Randall     |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Valere Jean Swoboda</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 6, 1984</b>  |  |   |  |
| 3 SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>June 29, 1925</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6229 Pioneer Drive</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baltimore</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>13c. CITY OR TOWN</b> <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>6229 Pioneer Dr. Balto. MD. 21214</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Raymond L. Belhumeur</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Helen Morton</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>218-14-1792</b>   |  | 17. INFORMANT ADDRESS <b>Walter A. Swoboda, same as 13e</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Severe, generalized arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 months</b> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Carcinoma of large bowel + intestinal obstruction relieved by lysis.</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>6/19/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-38</b> 19 <b>83</b> , to <b>2/6</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/6</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Jaime Punzalan</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED <b>2-8-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jaime M. Punzalan MD</b>  |  |   |  | 22e. ADDRESS <b>5214 Harford Rd. Baltimore, Maryland</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2/9/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Vets.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 9 1984</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Casper</b>  |  |   |  |

BP

1951

2/1/62

1999

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04498

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |  |  |
| Alice M Swol   |  |  | 2-12-84   |  |  | 0255 a.m.   |  |  |
| 1. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  | 7. IF UNDER 1 YEAR  |  |  |
| Fem  | White  | 10 15 1918   | 65 YRS.   |  |  | MONTHS DAYS HOURS MIN.  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |   |  |  |
| Mass.  | U.S.A.   |  | Baltimore MD.   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| Baltimore  | St. Agnes Hospital EM. ROOM  |  | Assembler   |  |  | Westinghouse  |  |  |
| 13a. STATE   |  |  | 13b. CITY OR TOWN   |  |  | 13c. STREET ADDRESS   |  |  |
| Baltimore  |  |  | Annapolis   |  |  | 1303 Poplar Ave. #21207   |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                        |  |  |   |  |  |
| Stanley Szalain  |  |  | Mary Vitrowski  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS   |  |  |
| No   |  |  | 016-10-3644   |  |  | 900 S. Caton Ave. Balto. Md. 21229  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) 4100 CARDIAC ARREST: ASYSTOLE  |  |  |   |  |  |   |  | MINUTES  |
| DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION   |  |  |   |  |  |   |  | MINUTES  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD   |  |  |   |  |  |   |  | YEARS  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |  |   |  |  |   |  |  |
| HYPERTENSION.  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-03 19 80, to PRESENT, that (I) (we) last saw the deceased alive on 1-12 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE DEGREE  |  |  |   |  |  | 22c. DATE SIGNED  |  |  |
| Oscar E. Fernandez M.D.  |  |  |   |  |  | 13 Feb 84   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |  | 22e. ADDRESS  |  |  |
| Dr. Fernandez, M.D.  |  |  |   |  |  | 5550 Baltimore National Pike 21228  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |
| Burial   |  |  | 2/15/84   |  |  | Loudon Park Cemetery  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  | 24b. ADDRESS  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |
| Ambrose, Inc.  |  |  | 1328 Sulphur Spring Rd. 21227                                       |  |  | FEB 14 1984   |  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  | Lila K. Smith   |  |  |   |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/cremation permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, a serious injury, or other traumatic event, the medical examiner will be notified.

MOOSEHEAD

MINUTES  
CARDIAC ARREST : 4:15 PM  
MINUTES  
ACUTE MYOCARDIAL INFARCTION  
YEARS  
HYPERTENSION.

PRESENT

80

11-03

51-1

Dr. E. F. Fennell, M.D.  
STATE E.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>SARA TABAK  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 26 84 |   |  | 2b. HOUR<br>12 <sup>25</sup> P M  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 6 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balt. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Balt. City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Levinale Hebrew Home & Chas. H. H. |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Md. |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Balt. City   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LOUIS COHEN  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA UNKNOWN   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>215-12-1156  |  | 17. INFORMANT ADDRESS<br>MR. CHARLES RAPPA 4305 GLENARM AVE. 21206  |   |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA

5070  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)  
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

BRAIN TUMOR, DECUBITUS ULCER

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from 1/28/84 to 2/26/84, that (we) last saw the deceased alive on 2/26/84, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>[Signature]  |  |  |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>2/26/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ESTRELLITA O. KUN, M.D.   |  |  |  | 22e. ADDRESS<br>LEVINALE HEBREW AGRIATRIC CENTER + HOSPITAL                          |  |   |  |

|  |  |                      |  |  |  |   |  |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>2/27/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEM FRIEDEL MARYLAND LODGE |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTIMORE MARYLAND |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 29 1984                     |  |   |  |
|  |  |                      |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                        |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

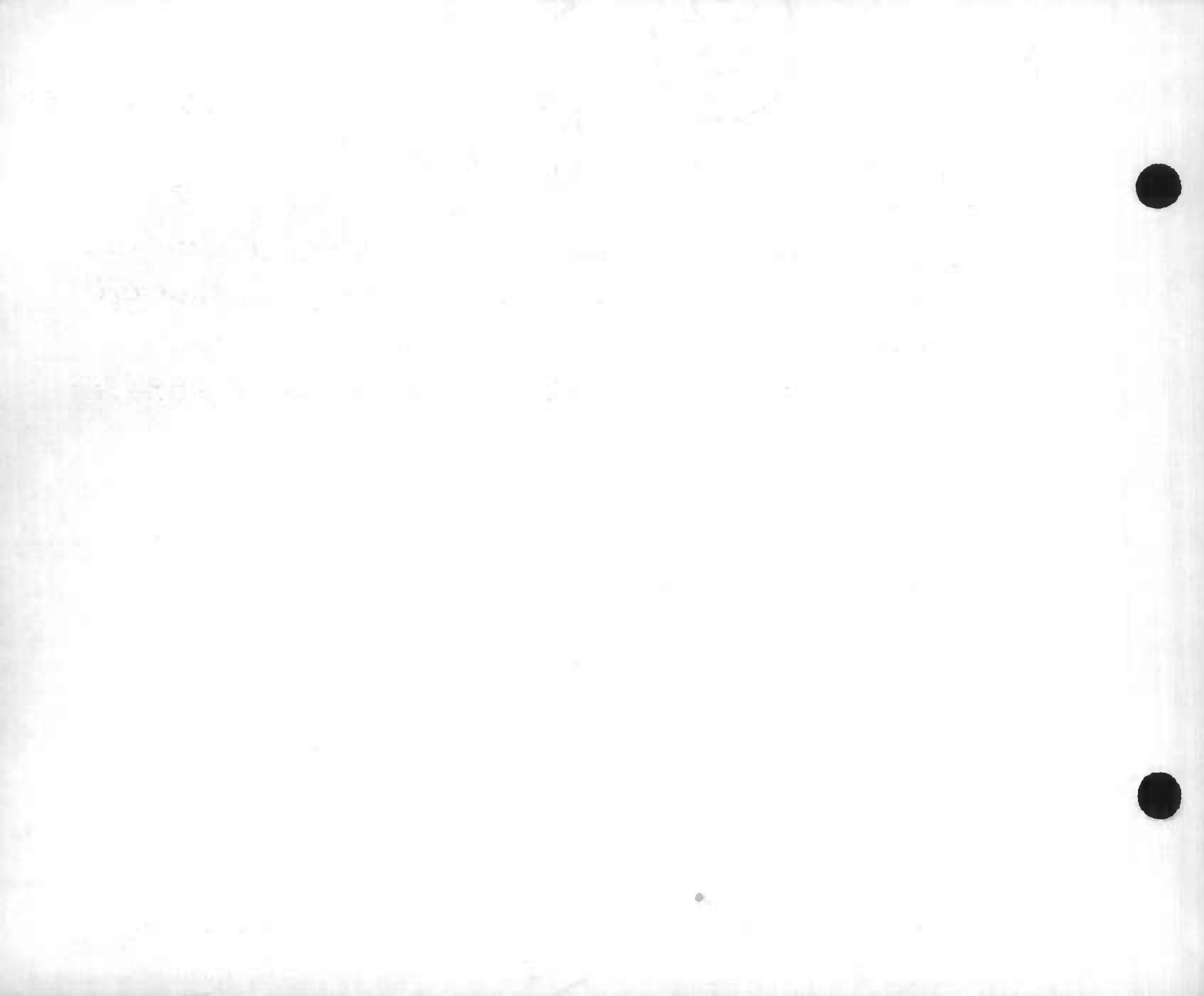
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04500

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph Tagliabue   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 18 84                         |   |  | 7b. HOUR<br>12 <sup>30</sup> A.M.  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 24 93   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90  |  | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Boiler Maker  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>2812 Goodwood Rd 21214   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis Tagliabue   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Angiolina Mensi  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |   |  | 16b. SOCIAL SECURITY NO.<br>08903-4487  |  | 17. INFORMANT<br>ADDRESS<br>Mr Joseph Tagliabue 141 McKinley Ave. Albertson, N.Y.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis<br>0389<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Renal failure, adenocarcinoma of prostate.  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17/84 to 2-17-84, that (I) (we) lost saw the deceased alive on 2-17-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Reddy   |  |   | DEGREE<br>MD   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/18/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph B. Reddy  |  |   | 22e. ADDRESS<br>Good Samaritan Hospital, Baltimore, MD 21239           |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>2/20/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakeview |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville, Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH     |  |   |  |   | REG. NO.  |  |  |
|--|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 0 4 5 0 1   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JENTRY JACKSON TASCI            |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEBRUARY 11, 1984 |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 - 19 - 83  |   | 2b. HOUR<br>1:14 A <sub>M</sub>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS<br>2 23 YRS.   |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 12c. STREET ADDRESS / ZIP CODE<br>17 1/2 Naylor Ave. 08069  |   | 12d. STREET ADDRESS / ZIP CODE<br>17 1/2 Naylor Ave. 08069   |  |
| 13a. STATE<br>N.J.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Pennsgrove   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Kenan Tasci                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Daylene Eby  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |   | 16b. SOCIAL SECURITY NO.<br>-  |  |
| 17. INFORMANT<br>ADDRESS<br>Kennewick, Washington.<br>Dorothy Eby 1514 W. 4th Ave. 99336 |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>4860 IMMEDIATE CAUSE (a) Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonitis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Immediate<br>2 days<br>2 weeks |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>none                  |   | 19a. DATE OF OPERATION   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                               |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from 2/9, 19 89, to 2/11, 19 84, that (I) (we) lost<br>saw the deceased alive on 2/4, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                            |  | 22b. SIGNATURE<br>Pamela J. Stone MD  |   | 22c. DATE SIGNED<br>2/11/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Pamela J. Stone                                 |  | 22e. ADDRESS<br>600 N. W. 11th St. BALTO. 12, 2nd   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>2-14-84   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Desert Lawn Mem.                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Kennewick Wash.   |  | 24. FUNERAL DIRECTOR<br>NAME<br>3331 Brehms Lane Balto. Md.<br>Schimunek Funeral Home, Inc. 21213   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 14 1984   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                     |  |   |  |   |   |  |  |

RECEIVED  
JAN 10 1973  
FBI  
JAN 10 1973  
FBI

RECEIVED  
JAN 10 1973  
FBI  
JAN 10 1973  
FBI

RECEIVED  
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RECEIVED  
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JAN 10 1973  
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BISHOP Ellen E. Tate   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 2 84 |   |  | 2b. HOUR<br>3:45A M   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 16 20  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>NC  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wyman Park Health System, Inc. |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Stewart   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha (Williams)  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>220-18-4415   |  | 17. INFORMANT<br>ADDRESS<br>Anthony Tate 2608 Guilford Avenue<br>Chart  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE<br>1579 Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Pancreatic Cancer<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 min<br>3 months  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br>None   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br>12/30/83  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Pancreatic Carcinoma  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from January 1, 1984, to February 2, 1984, that I (we) last saw the deceased alive on February 2, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.)  |  |   |   |   |  |   |  |
| 23. SIGNATURE<br>Mark A. Talamini   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>2/2/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mark Talamini MD   |  |   |   | 22e. ADDRESS<br>Wyman Park Health System, Inc.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2/9/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. National Cem. Baltimore, Md.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 6 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Grace   |  | MIDDLE<br>Virginia  |  | LAST<br>Tauber   |  | 20. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>2-19 1984                           |  | 26. HOUR<br>M<br>8:00<br>a.m.                              |  |
| 3. SEX<br>F.  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN. 10, 1910   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>74 YRS.  |  | IF UNDER 1 YR<br>MONTHS DAYS HOURS MIN  |  | 7. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2-19 1984     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |   |  |  |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Jenkins Memorial Hospital N.H. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECRETARY                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>GAS & ELECT.                                   |  |  |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 13e. STREET ADDRESS<br>1000 SOUTH CATON AVE. 21229                                  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANCIS JEROME TAUBER   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELIZABETH WOOD   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO         |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>212-05-4162   |  |  |  | 17. INFORMANT<br>MARGARET L. DASHIELL   |  |  |  | ADDRESS<br>326 STEVENSON LA. 21204  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>9531<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 2-19 1984   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject put bag over head |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Hospital   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1000 S. Caton Ave., Baltimore, Maryland               |  |   |  |  |  |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth, M.D.</i>  |  |  |  | TITLE (SPECIFY)<br>Assistant  |  |  |  | MEDICAL EXAMINER<br>DATE SIGNED 2-19-84   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  |  |  | ADDRESS<br>111 Penn Street  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  |  | 23b. DATE<br>FEB. 22, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WOODLAWN CEM.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WOODLAWN BALTIMORE MD.                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME   |  |  |  |   |  | ADDRESS<br>6500 YORK RD. 21212   |  | 25. DATE REC'D. BY REGISTRAR<br>FEB 23 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jula Davidson-Randall</i> |  |

AT 11:11 AM

11-11-11

*Handwritten signature*

48833 104

11-11-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  | REG. NO.  |  |
|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BOWEN ACTON TAYLOR</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>25</b> YEAR <b>84</b>                     |  | 2b. HOUR <b>6:40 AM</b>   |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUC.</b>  | 5. DATE OF BIRTH<br>MONTH <b>06</b> DAY <b>04</b> YEAR <b>05</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOV'T</b>                  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>3651 HINELINE ROAD, 21229</b>                 |  |
| 14. FATHER'S NAME<br>FIRST <b>GEORGE</b> MIDDLE <b>TAYLOR</b> LAST <b>TAYLOR</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>A.</b> LAST <b>BOSWELL</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-03-4976</b>  | 17. INFORMANT<br>ADDRESS <b>LENA L. HAZY 544 FOREST VIEW ROAD 21090</b>              |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular arrest</b><br><b>4148</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ischemic Cardiomyopathy</b> |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>about 2 years</b><br><b>about 5 years</b>                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-10</b> , 19 <b>84</b> , to <b>2-25</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>R. Girgis</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/25/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Raafat Y. Girgis</b>  |  |   | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>                       |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>02-29-84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE CITY</b> COUNTY <b>MARYLAND</b> STATE   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 27 1984</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>              |  |



THIRTEEN



POST OFFICE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04505

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |  |   |   |  |  |
|--|--|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George P. Taylor</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-28-84</b>                  |   |   | 2b. HOUR<br><b>3:10 PM</b>   |   |   |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 8 26</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GEN.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shoe</b>  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3563 6th Street 21225</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Taylor</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Nolan</b>    |   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>W.W. II</b>                             |   | 17. INFORMANT ADDRESS<br><b>214 20 5292 Margaret Fuller 313 S. Hammonds Ferry</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b>   |  |  |  |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Right Pneumonectomy for Lung Cancer</b>   |  |  |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-18</b> , 19 <b>84</b> , to <b>2-28</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-28</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Martin Guerrero MD</b>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2-28-84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Martin Guerrero</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>30050 Hanover St., Balti. MD</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>3/3/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b>                    |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce 4001 Ritchie Hgwy</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1984</b>   |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians are to retain the original certificate and a copy of the certificate should be filed with the funeral director. The funeral director should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

21

George P. Taylor

3-18-24

22

Y 3 25

W. S. H.

W. S. H.

South Baltimore

Baltimore

Johns Hopkins

Johns Hopkins

Johns Hopkins

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04506

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN O. TAYLOR  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 4 84                    |   | 2b. HOUR<br>3:30P M   |
| 3. SEX<br>Male  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 12 21   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>N. Carolina   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD.               |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, BALTIMORE, MARYLAND 21218 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   | 13b. COUNTY  |   |   |
| 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>1401 N. Kenhill Avenue 21213            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Taylor   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Anders   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>237-24-5693  |  | 17. INFORMANT<br>ADDRESS<br>John E. Taylor 729 East 22nd Street           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4280 SEVERE CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>28 HRS       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                         |   |
| 22a. I certify that (this hospital) attended the deceased from 1-30-1984 to 2-4-1984. The (we) last saw the deceased alive on 2-4-1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. <input checked="" type="checkbox"/> |  |   |  |   |   |
| 22b. SIGNATURE<br>Howard Jacobs, MD   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>2/5/84  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HOWARD JACOBS, MD  |  | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  | 23b. DATE<br>2/9/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA                  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills, Md.   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H Inc. 1101 E North Avenue   |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 6 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith   |  |   |   |

1041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 08-01-01 BY 60322

1968  
10/10/68

1968

10/10/68



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIAN REGINA TAYLOR</b>               |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02-13-84</b> |   |  | 2b. HOUR<br><b>3:15 A<sub>M</sub></b>   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-11-1923</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERVISOR</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>J.H. UNIVERSITY</b>                       |  | 13a. STREET ADDRESS<br><b>2815 EMERALD RD. 21234</b>  |  |   |  |   |  |
| 13b. STATE<br><b>MD.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2815 EMERALD RD. 21234</b>                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY TRAUTMAN</b>                   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE BIGGINS</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>216-12-5659</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Melvin C. Taylor - 2815 Emerald Rd. 21234</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Amiotrophic lateral sclerosis**  
**3352**  
 DUE TO, OR AS A CONSEQUENCE OF  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
 (b) \_\_\_\_\_  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> , 19 <b>84</b> , to <b>2/13</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Brian H. Kahn, MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/13/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRIAN H. KAHN, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>THE UNION MEMORIAL HOSPITAL</b>   |  |  |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2-16-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John Davidson-Randell</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 15 1984</b>        |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNIVERSITY

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1918-1919

1918-1919



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04508

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |  |  |  |
|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT M TAYLOR</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 23 84</b> |   |  | 2b. HOUR<br><b>11:15 P M</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 24, 1952</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>31</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hosp.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tile Mechanic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |

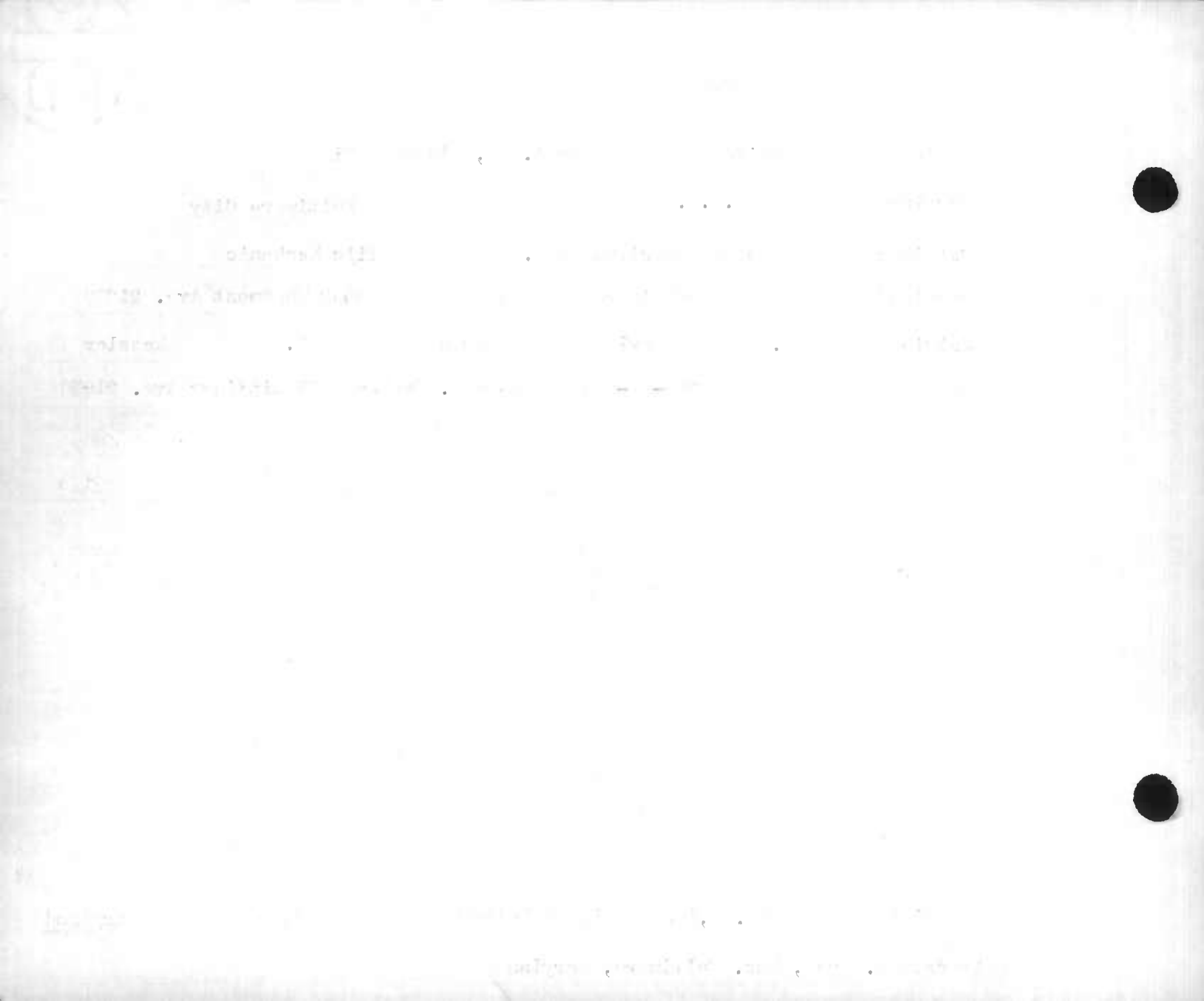
|   |  |  |                                 |  |  |  |  |  |   |  |  |   |  |  |
|---|--|--|---------------------------------|--|--|--|--|--|---|--|--|---|--|--|
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b> |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                      |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5502 Woodmont Ave. 21239</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Calvin A. Taylor</b>   |  |  |                                 |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alberta G. Kessler</b> |  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |  |                                 |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-58-3298</b>                             |  |  | 17. INFORMANT ADDRESS<br><b>Laura A. Taylor 1279 Gittings Ave. 21039</b>                        |  |  |   |  |  |

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic Shock</b><br><b>5679</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Generalized Peritonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b><br><b>2 days</b> |  |
|---|--|--|--|--|--|--|--|--|--|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Alcoholic liver disease &amp; cirrhosis &amp; G.I. bleeding, renal failure</b> |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/5/84</b> 19 <b>84</b> , to <b>2/23/84</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/23/84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>CHANDRANATH L. DAS</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/23/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHANDRANATH L. DAS</b>   |  |  |  | 22e. ADDRESS<br><b>24 DOWLING CIRCLE, B-2, BALTIMORE MD 21234</b>  |  |  |  |

|  |  |                                   |  |   |  |   |  |
|--|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                       |  | 23b. DATE<br><b>Feb. 27, 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 27 1984</b>         |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

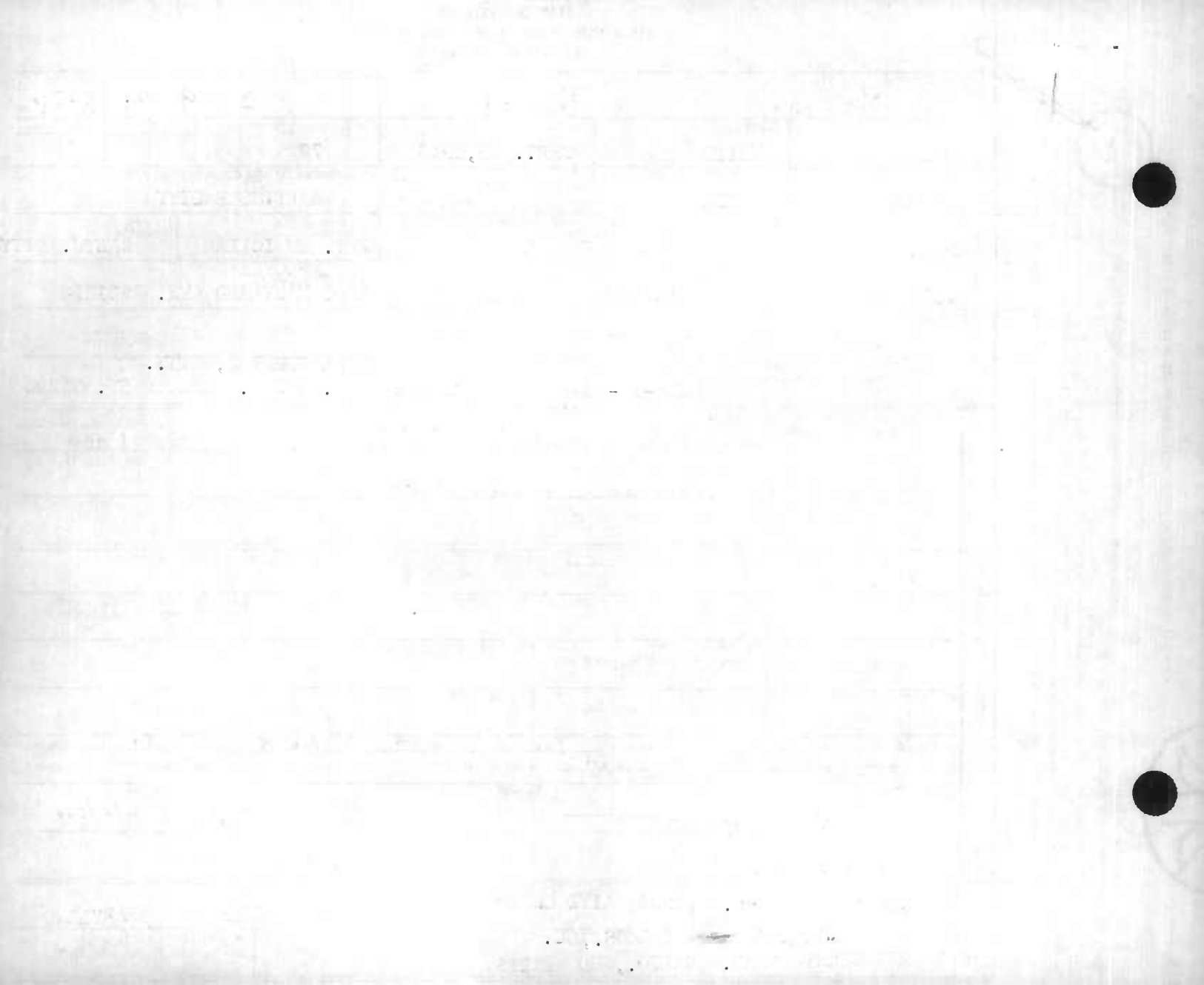
04509

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |  |  |
|--|--|--|---|--|--|---|--|--|
| Nathan Ternoff   |  |  | 2 9 84  |  |  | 845 P.M.  |  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  |  | 7. IF UNDER 1 YEAR  |  |  |
| MALE   | WHITE  | SEPT. 13, 1913   | 70 YRS.   |  |  | MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |   |  |  |
| RUSSIA   | USA  |  | BALTIMORE CITY MD.  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| BALTIMORE  | MERCY HOSPITAL   |  | RET. MUNICIPAL EMPLOYEE                                       |  |  | BALTO. CITY   |  |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  |
| MARYLAND   |  |  | BALTIMORE   |  |  | BALTIMORE   |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |  | 16. INSIDE CITY LIMITS?   |  |  |
| HENRY TERNOFF  |  |  | ANNIE UNKNOWN   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  | 16b. SOCIAL SECURITY NO.                                      |  |  | 17. INFORMANT   |  |  |
| NO   |  |  | 218-10-5840   |  |  | EMANUEL GORDINE, ATTY.  |  |  |
|  |  |  | 900 GARRETT BLDG. 233 E. REDWOOD ST. 21202                    |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction   |  |  |   |  |  |   |  | 1 day  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |  |   |  |  |
| (b) Anterograde reticular disease  |  |  |   |  |  |   |  |  |
| (c)  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |   |  |  |
| Diabetes   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2) |  |   |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |  |   |  |  |
|  |  | P.M. 19  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |  |   |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   | CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 8 19 84, to Feb 9 19 84, that (I) (we) last saw the deceased alive on Feb 9 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   | 22c. DATE SIGNED   |  |   |  |  |
| Donald M. Lai  |  |  |   | 2/9/84   |  |   |  |  |
| 22d. ADDRESS   |  |  |   | 22e. DATE REC'D. BY REGISTRAR  |  |   |  |  |
| Mercy Hospital   |  |  |   | FEB 17 1984  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |
| BURIAL   |  | FEB. 15, 1984  |   | AITZ CHAM  |  | BALTIMORE MARYLAND  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |  |   |  |  |
| SOL LEVINSON & BROS., INC.   |  |  |   | FEB 17 1984  |  |   |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |   | REGISTRAR'S SIGNATURE  |  |   |  |  |
|  |  |  |   | [Signature]  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04510

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>IDA TERRELL  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 12, 1984                     |   |   | 2b. HOUR<br>3:48 AM  |   |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 1 21   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD.   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MEADE REAVIS  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY                        |   |   | 13e. STREET ADDRESS / ZIP CODE<br>4103 LIBERTY HGTS. AVE. 21207  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>220-14-0557                                      |   | 17. INFORMANT<br>ADDRESS<br>WALTER TERRELL 4103 LIBERTY HGTS. AVE.                      |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>sepsis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>bowel infarction</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u><br><u>24 hr</u><br><u>24 hr</u> |  |   |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br>2/11/84   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Mesenteric ischemia      |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. NA 19                |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)<br>NA |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>NA |   | 21f. LOCATION<br>STREET<br>NA   |  | CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21/84</u> 19 <u>84</u> , to <u>2/12/84</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Feb. 12</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>Alicia B. Brown   |  |   | DEGREE<br>MD   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>2/12/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Alicia B. Brown  |  |   | 22e. ADDRESS<br>550 N. Broadway, Baltimore, Md.                              |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(S) BURIAL   |  |   | 23b. DATE<br>2/15/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GARRISON FOREST VET. CEM.                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>REISTERSTOWN                                      |  |  |
| 24. FUNERAL DIRECTOR<br>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 14 1984                                 |   |   |  |   |  |  |

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Mo.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04511

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lillian M. Terrys   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 7, 1984                    |  | 2b. HOUR<br>8:20PM   |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 17 1920  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tailor | 12b. KIND OF BUSINESS OR INDUSTRY<br>Grue Bros. Co.                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>-   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Adolph Tarasewicz   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Gigis                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-09-1215  |  | 17. INFORMANT<br>ADDRESS<br>5518 Plainfield Ave.<br>Alqert Terrys (brother) 21206    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>v (c) <u>Arteriosclerotic Cardiovascular Disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>JANUARY 26, 1984</u> , to <u>FEBRUARY 7, 1984</u> , that (1) <input checked="" type="checkbox"/> I lost saw, the deceased alive on <u>FEBRUARY 7, 1984</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> I did not view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Walker Impagliatelli</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>2/7/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Walker Impagliatelli M.D.  |  | 22e. ADDRESS<br>Church Hospital 100 Broadway North  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2/11/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer                        |  | 23d. LOCATION<br>Baltimore Maryland 21231<br>Baltimore Md.   |
| 24. FUNERAL HOME FOR NAME<br>Schmunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 10 1984                               |  |  |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Samuel C. Smith</i>                       |  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



EXHIBIT A

FOOT COTTON

EXHIBIT A



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |                                     | REG. NO.   |  |  |  |
|--|--|--|---|--|-------------------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |  |                                     | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 7b. HOUR   |  |
| AGNES  |  |  | THOMAS  |  |                                     | 2 19 84  |  | 139A M   |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH MONTH DAY YEAR  |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR IF UNDER 24 HRS                                |  |
| Female   |  | Black  |   | 7 23 10  |                                     | 73 YRS.  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| Maryland   |  | U.S.A.   |   |  |                                     | Baltimore city MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| city   |  | BON SECOURS HOSPITAL   |   |  |                                     |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |                                     | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |
| Maryland   |  |  |   | Baltimore  |                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 110 S. Catherine St. 21223                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |                                     |  |  |  |  |
| George Freeman   |  |  | Lodie   |  |                                     |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS               |  |  |  |  |
| NO   |  |  | 217-20-6496   |  | Anthony Thomas 110 S. Catherine St. |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral vascular disease</u><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  |                                     |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |                                     |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                     | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   |  |                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  |  |  | P.M. 19   |  |                                     |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                     | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
|  |  |  |   |  |                                     | 131 3/19 84  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/19</u> , 19 <u>84</u> , to <u>3/19</u> , 19 <u>84</u> ; that (I) (we) last saw the deceased alive on <u>2/19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                     |  |  |   |  |                                     |  |  |  |  |
| 22b. SIGNATURE   |  |  | DEGREE  |  |                                     | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| Kuang-Yen Huang MD   |  |  |   |  |                                     |  |  | 3/19/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |                                     |  |  |  |  |
| KUANG-YEN HUANG  |  |  | BON Secours Hospital  |  |                                     |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                     | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| BURIAL   |  | 2/24/84  |   | Mount Auburn Cem.  |                                     | Baltimore Md.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |   |  |                                     | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |
| Wm C March F/H Inc. 1101 E North Avenue  |  |  |   |  |                                     | FEB 21 1984  |  |  |  |
|  |  |  |   |  |                                     | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
|  |  |  |   |  |                                     | Julia Davidson Nordell   |  |  |  |

BP

FORM 1

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04513

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Anna(e) E. Thomas</b>                                 |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 15, 1984</b>                           |   | 2b. HOUR<br><b>3:55P</b>  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 - 8 1919</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secoure Hospital, Baltimore,</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Md Retired</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>0</b>                     |   |
| 13a. STATE<br><b>Md</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hunter Hunt</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Rogers</b>                   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input type="checkbox"/> YES, GIVE WAR OR DATES |  | 16b. SOCIAL SECURITY NO.<br><b>0</b>  |   | 17. INFORMANT<br><b>Rosa Brooks, 874 W. Fayette St. 21201</b>     |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIAC ARREST****4148**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Arrhythmia**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) **congestive cardiomyopathy**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

**NONE**

MEDICAL CERTIFICATION

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/7</b> , 19 <b>84</b> , to <b>2/15</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2/15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>C D Kearney MD</b>   | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>2/16/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHRISTOPHER D. KEARNEY</b>  |  | 22e. ADDRESS<br><b>Bon Secours Hosp</b>  |  |

|  |                             |   |  |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                  | 23b. DATE<br><b>2/20/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Law Funeral Home 4611 Park Heights Ave.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1984</b>     |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>                    |                             |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

123456

43

PIPI

(9)

John

John

John

John

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.


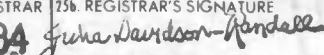
BP

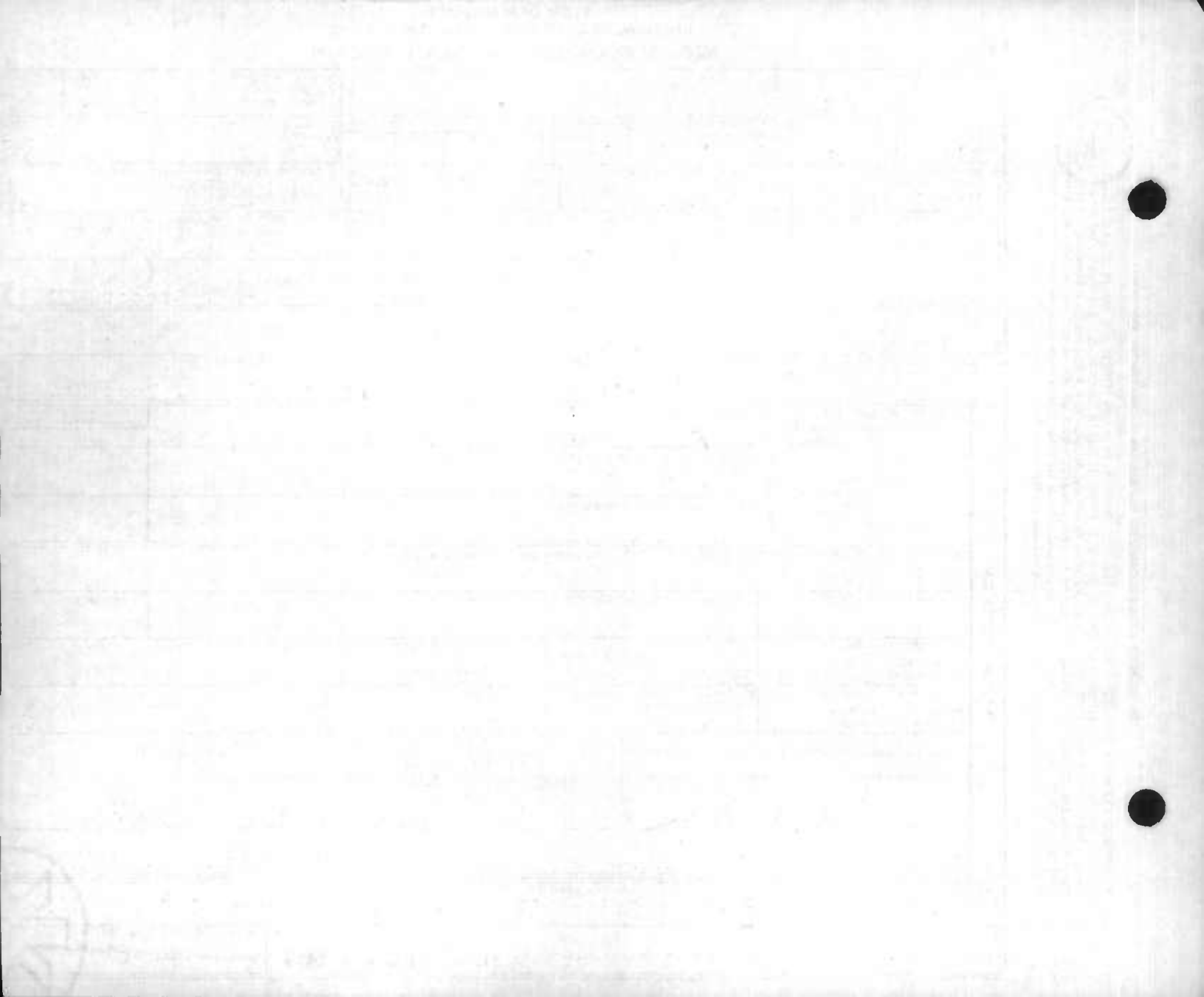
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                        |  |  |
|--|--|--|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>ANTOMAR   |  |  | MIDDLE<br>THOMAS   |  |  | LAST<br>THOMAS  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR |  |  | 2b. HOUR<br>M  |  |  |                        |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>Black   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 16 69  |  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>14 YRS.   |  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 15 19 84 |  |  | 2d. HOUR<br>11:45 p.m. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |  | MD.   |  |  |  |  |  |                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1502 N. Port St. |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |  |  |  |                        |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br>Baltimore   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  | 13e. STREET ADDRESS<br>1502 N. Port Street 21213  |  |  |  |  |  |                        |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jesse Thomas   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sylvia Pridget  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  |  | 17. INFORMANT<br>Sylvia Pridget  |  |  | ADDRESS<br>1502 N. Port St.   |  |  |   |  |  |  |  |  |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot wound of neck (handgun)</u><br>9650<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |  |                        |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                        |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |  |   |  |  |  |  |  |                        |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>11:42xx 2-15-19 84  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject was shot.   |  |  |   |  |  |   |  |  |  |  |  |                        |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1502 N. Port St., Balto. Md.  |  |  |   |  |  |   |  |  |  |  |  |                        |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                        |  |  |
| ACTUAL SIGNATURE<br>  |  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |  | MEDICAL EXAMINER   |  |  | DATE SIGNED<br>2-16-84  |  |  |   |  |  |  |  |  |                        |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |  | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  |  | 23b. DATE<br>(TYPE OR PRINT)<br>2/23/84  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co, Md.  |  |  |   |  |  |  |  |  |                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc.  |  |  | ADDRESS<br>1101 E North Avenue   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984   |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |   |  |  |  |  |  |                        |  |  |



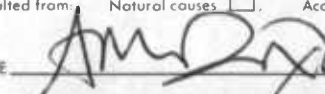

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                         |  |  |  |   |  |   |  |   |  |   |  |                                   |  |
|--|--|-------------------------|--|--|--|---|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LERONAH VERNICE ADAMS THOMAS</b>  |  |                         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2 1 1984</b> |  |   |  | 2b. HOUR<br>M <b>10:17</b>        |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 7 54</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>30 YRS.</b>                     |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>2 1 1984</b>  |  | 2d. HOUR<br>M <b>10:17</b>  |  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                       |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>street - 2420 Lakeview Ave.</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2405 Lakeview Ave. 21217</b>  |  |   |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Adams</b>  |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisy Green</b>   |  |   |  |   |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>UNKNOWN</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br><b>Minnie Williams 2405 Lakeview Ave.</b> |  |   |  |   |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9682</b> IMMEDIATE CAUSE (a) <b>Blunt force cranio-cerebral trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |                         |  |  |  |   |  |   |  |   |  |   |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                         |  |  |  |   |  |   |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR <b>10</b> P.M. MONTH DAY YEAR <b>2-1-1984</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject was beaten.</b>   |  |   |  |   |  |                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2400 blk. Lakeview Ave., Balto. City Md.</b>  |  |   |  |   |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |   |  |   |  |                                   |  |
| ACTUAL SIGNATURE<br>  |  |                         |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>2-2-84</b>   |  |   |  |   |  |                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |  |                         |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>  |  |   |  |   |  |   |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(b) <b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>2/8/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cemetery</b>      |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lansdowne, Md.</b>                                     |  |   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b> ADDRESS<br><b>1101 E North Avenue</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 7 1984</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |                                   |  |

R1211 NORTH



Items 18-22a 3/12/84 F#589 mtb

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

0 4 5 1 6

FOR  
1- STATE  
REGISTRAR

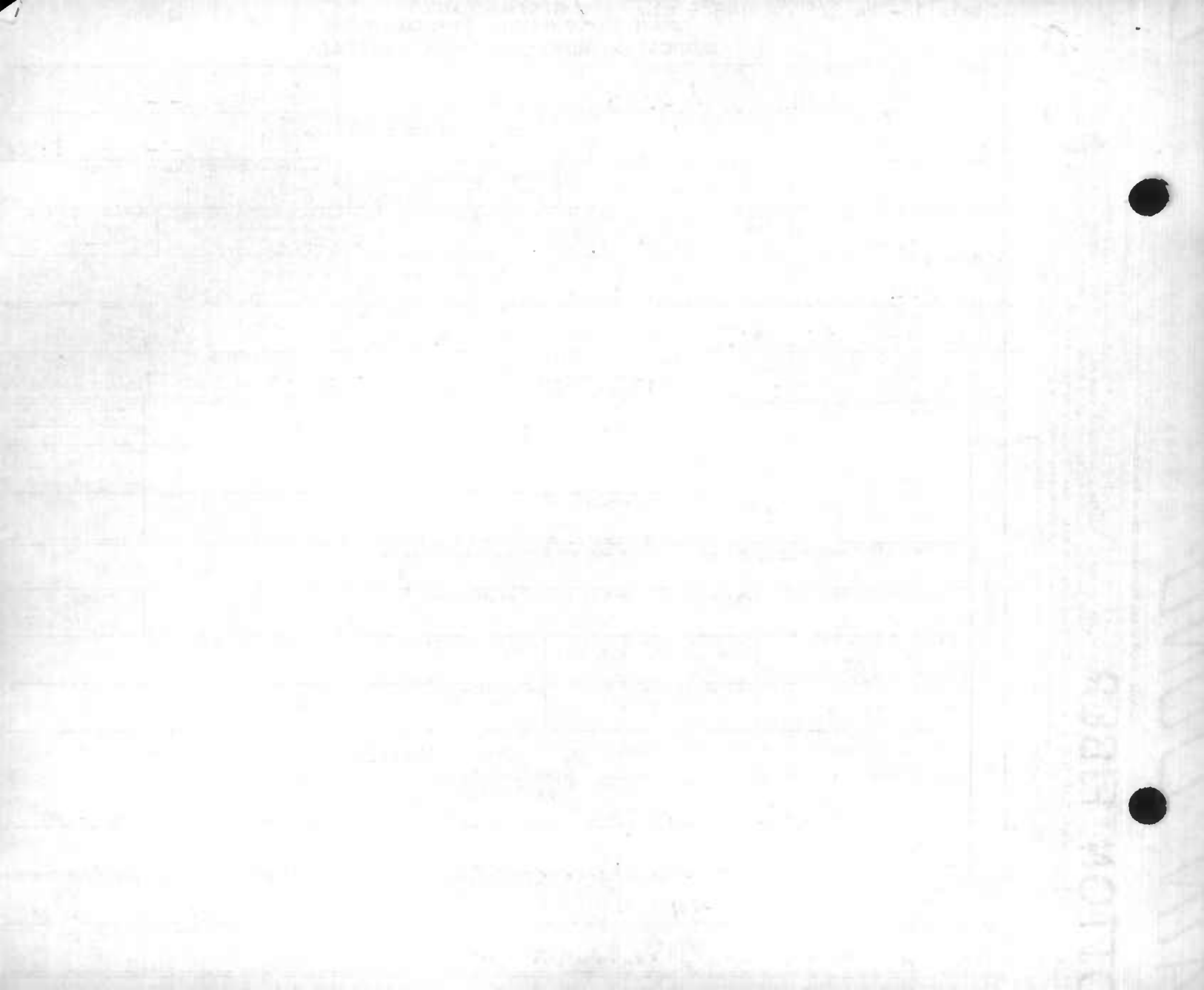
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |               |   |   |  |  |  |  |   |
|---|---------------|---|---|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LOUIS L. THOMAS  |               |   | 2a. DATE KNOWN OF DEATH<br>2-9-84 19      |  |  | 2b. HOUR<br>M  |  |   |
| 3 SEX<br>MALE   | 4 RACE<br>BIK | 5. DATE OF BIRTH<br>5 30-1920 63 YRS.   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.   | 7c. DATE PRONOUNCED DEAD<br>2-9-84 19  | 7d. HOUR<br>6:30P  |   |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5426 Sarrill Rd. Apt. D |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>Md  |               | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>BALTO.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES EDWARD THOMAS   |               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MILDRED LYONS  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>213/28/6422  |  | 17 INFORMANT<br>ADDRESS<br>MRS. MILDRED THOMAS 1728 PULASKI ST. 21217 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |               |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)  |               |   |   |  |  |  |  |   |
| 19a. DATE OF OPERATION  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  |  | 20 AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |               |   |   |  |  |  |  |   |
| ACTUAL SIGNATURE<br>Margarita A. Koroll, M.D.   |               | TITLE (SPECIFY)<br>M.D. Assistant   |   |  |  |  | DATE SIGNED<br>2-10-84   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |               | ADDRESS<br>111 Penn Street  |   |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |               | 23b. DATE<br>2-13-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEM PARK   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ARBUTUS BALTO. MD.                     |  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>JOSEPH L. RUSS   |               |   |   | ADDRESS<br>2222 W. NORTH AVE.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1984   |  | 25b. REGISTRAR'S SIGNATURE  |

BP 552

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME FOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |                           |  |
|---|--|--|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ODESSA THOMAS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 6, 1984</b> |  | 2b. HOUR<br><b>12:42p</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 20 14</b>                     |                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>69</b>          |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.        |                           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                           |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                    |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Davis</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nannie Offer</b>   |  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>218-22-9945</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Patricia Mack 1004 N. Caroline Street</b> |                           |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIAC ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**MINUTES**

DUE TO, OR AS A CONSEQUENCE OF

4310  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

**INTRACEREBRAL HEMORRHAGE****2 days**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**HYPERTENSION ATHEROSCLEROSIS****YEARS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**ANTICOAGULATION**

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2/4</u> , 19 <u>84</u> , to <u>2/6</u> , 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>2/6</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Thomas Chambers</i>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/6/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS CHAMBERS</b>   |  | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALTO. MD.<br/>JOHNS HOPKINS HOSPITAL 21205</b> |  |  |  |   |  |

|  |  |                             |  |  |  |  |  |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE CAPT)<br><b>BURIAL</b>                         |  | 23b. DATE<br><b>2/10/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Mem Pk</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b> |  |                             |  | 25a. DATE RECD. BY REGISTRAR<br><b>FEB 7 1984</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carver</i>              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after date of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the attending physician must complete the report of death.

10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04518

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM EVERETT THOMAS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>6</b> YEAR <b>84</b>                                 |  | 2b. HOUR<br><b>1255 A</b><br>M   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>6</b> YEAR <b>19</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreman</b>              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Warehouse</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1035 Wilmington Avenue 21229</b>  |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)<br><b>Barney Thomas</b>   |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)<br><b>Ella Crockett</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-12-0112</b>  | 17. INFORMANT<br><b>Floria J. Leimkuhler</b> ADDRESS <b>5507 Council St. 21227</b>              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of the Lung Met. to brain</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>12-29-83</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Right Lung</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOT BY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 2nd, 1984</b> to <b>Feb 6, 1984</b> , that (I) (we) lost saw the deceased alive on <b>Feb 6, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Faiz H. Behsudi</b>   |  | DEGREE  |   | 22c. DATE SIGNED<br><b>2-6-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Faiz H. Behsudi</b>  |  | 22e. ADDRESS  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2/11/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1984</b>   |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Davis</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **or** item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04519

1- STATE  
REGISTRAR

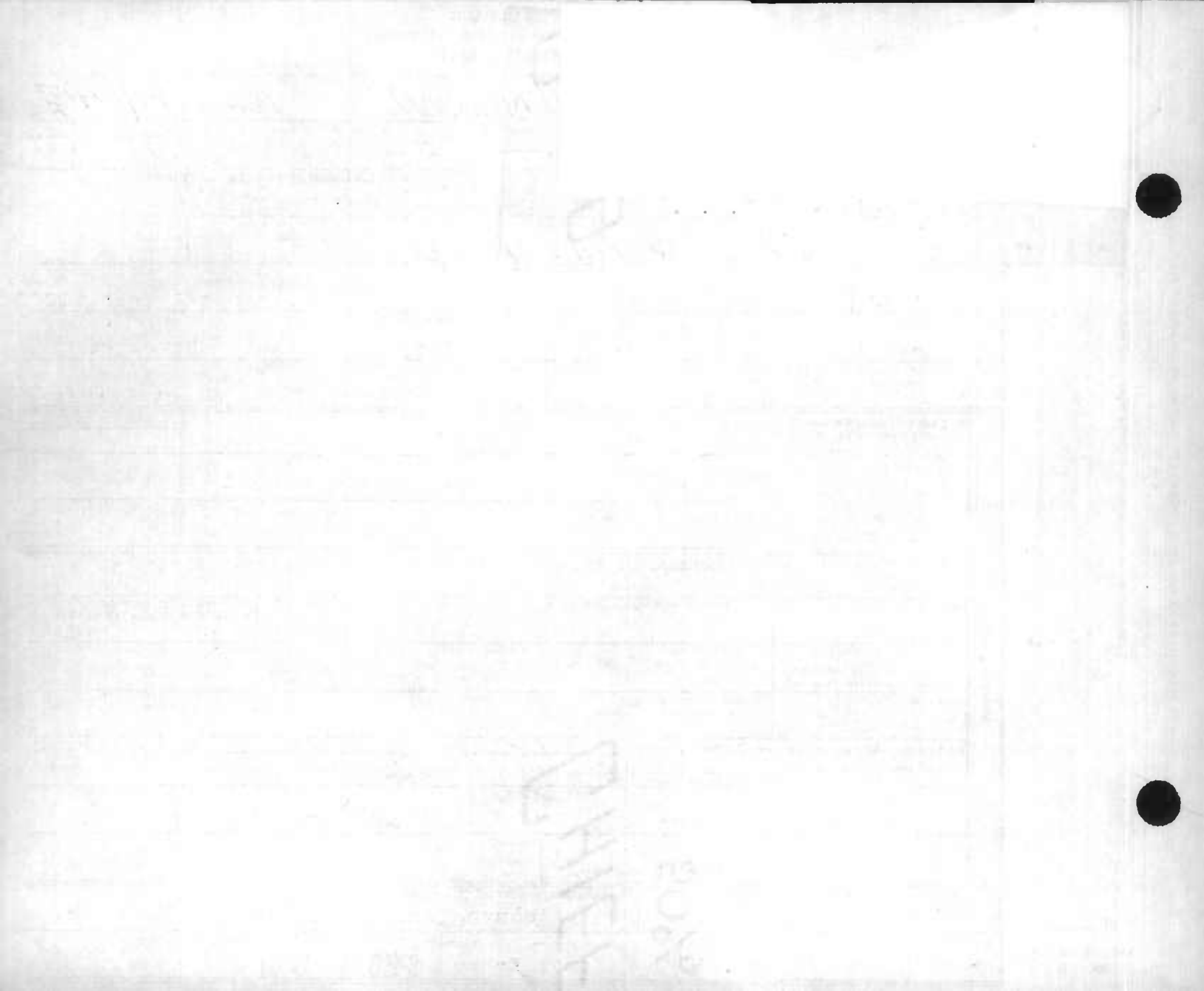
REG. NO.

|  |  |   |  |  |  |   |   |   |  |  |
|--|--|---|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Bessie V. Thompson</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>02-1-84</i>                     |  |  | 2b. HOUR<br><i>7:15 A.M.</i>  |   |   |  |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>Black</i>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR <i>12 12 05</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>78</i> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                           |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>West Virginia</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY, MD.</i>                              |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Bon Secours Hosp.</i> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><i>328 N. Mount Street 21223</i>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Samuel Tibbs</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Helen Devenger</i>   |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>UNKNOWN</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>N/A</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Pamela Webster 328 N. Mount Street</i>  |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4275 shock + CHF</i><br>IMMEDIATE CAUSE (d) <i>coronary + cardiac arrest</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)   |  |   |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/26</i> , 19 <i>83</i> , to <i>2/1</i> , 19 <i>84</i> , that (I) (we) lost<br>saw the deceased alive on <i>2/1</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.    |  |   |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Rolando A. Sabundayo</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |   | 22c. DATE SIGNED<br><i>2/1/84</i>                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Rolando A. Sabundayo</i>   |  |   |  | 22e. ADDRESS   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE INSTRUCTIONS)<br><i>BURIAL</i>   |  |   | 23b. DATE<br><i>2/4/84</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mount Auburn Cem.</i>                 |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Md.</i> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm C March F/H Inc. 1101 E North Avenue</i>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 2 1984</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                    |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |  |  |   |   |   |  |
|---|--|--|---|--|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GEORGE THOMPSON  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/12/84  |  |  | 2b. HOUR<br>47   |   |   |   |  |
| 3. SEX<br>M   |  | 4. RACE<br>B   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8/6/36   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>47 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                              |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br>MD  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTO   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>221 Schroeder St. 21223 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES THOMPSON  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HANNAN LEE THOMPSON   |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.<br>220304310   |  | 17. INFORMANT<br>DR. COHEN   |  |   |   | ADDRESS<br>BON SECOURS                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4029 CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) H-C-V.D.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |   |  |
| 22a. I certify that this hospital attended the deceased from 2/11/84 to 2/12/84 that the deceased saw the deceased alive on 2/12/84, and that in my opinion death occurred on the date and hour and from the causes stated above. (Howe) (did not view the body after death.)   |  |  |   |  |  |  |   |   |   |  |
| 22b. SIGNATURE<br>Howard B. Cohen   |  |  | DEGREE M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>2/12/84  |   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HOWARD B. COHEN  |  |  | 22e. ADDRESS<br>BON SECOURS HOSPITAL  |  |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>2-15-83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hawthorne Md.                                     |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chas. H. Powell   |  |  |   |  |  | ADDRESS<br>319 N. Schroeder St   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 14 1984  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |  |   |  |  |  |   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For 4 copies retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item #4 per ph. 2/10/84 kg

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGEANNA W. THOMPSON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>05</b> YEAR <b>84</b> |   |  | 2b. HOUR<br><b>830p</b> M   |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>Caucasion</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>09</b> DAY <b>22</b> YEAR <b>1993</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>H/W</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>ESSEX</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1 EASTERN BLVD 21222</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>ROSS</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>-</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-74-1864</b>   |   | 17. INFORMANT<br><b>LOUISE THOMPSON</b>   |  | ADDRESS<br><b>44 MOBILE LODGE DR.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>sepsis (urinary)</b><br><b>5990</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>-</b><br>(c) <b>-</b><br>DUE TO, OR AS A CONSEQUENCE OF                                 |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>@ inferior myocardial infarction @ bilateral cerebrovascular accidents @ decubitus ulcers</b>   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 3rd</b> , 19 <b>84</b> , to <b>Feb 5th</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Feb 5th</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard L. Linthicum MD</b>  |  |  |   |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/5/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD L. LINTHICUM</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>MERCY HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/8/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDEN OF FAITH</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD.</b>                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CONNELLY FUNERAL HOME OF DUNDALK</b>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 7 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>   |  |

MEDICAL CERTIFICATION

BP

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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02/23

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP \_\_\_\_\_  
DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR<br><i>Tip 21403</i>   |  | REG. NO.  |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>MARY ELIZABETH THOMPSON</i>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Feb 25 84</i>                           |  | 2b. HOUR<br><i>A. M.</i>   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Black</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Dec 28 1906</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>77</i>                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>md</i>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.                |  |  |  |
| 12. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>BON SECOURS</i>                                       |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Laundry</i> |  | 15. KIND OF BUSINESS OR INDUSTRY<br><i>U.S. NAVAL Acad.</i>  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>md</i>   |  | 13b. CITY OR TOWN<br><i>ANNAPOLIS</i>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><i>123 Eastern Ave 21403</i>                               |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John Eagle Brice</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Christine Motor</i>   |  | 16. ADDRESS<br><i>ANNAPOLIS, 21403</i>   |  |   |  |  |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 18. SOCIAL SECURITY NO.<br><i>213-30-6940</i>   |  | 19. INFORMANT<br><i>Wilbur W. Thompson</i>   |  |   |  |  |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>SEPTICEMIA</i><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>URINARY T. INFECTION</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>CVA</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>ASCUD</i> |  |   |  |  |  |   |  |  |  |
| 21a. DATE OF OPERATION   |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 22a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 23b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 24a. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 24b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 24c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 25. I certify that (I) (this hospital) attended the deceased from <i>2/25/84</i> 19 <i>84</i> to <i>2/25</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>2/25/84</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |
| 26. SIGNATURE<br><i>ngaydo</i>   |  | 27. DEGREE<br><i>MD</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 28. DATE SIGNED<br><i>2/25/84</i>   |  |  |  |
| 29. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Elmo M. Gaydo</i>   |  | 30. ADDRESS<br><i>Bon Secours Hosp - Baltimore</i>  |  |  |  |   |  |  |  |
| 31. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 32. DATE<br><i>3-1-1984</i>   |  | 33. NAME OF CEMETERY OR CREMATORY<br><i>PINE LAWN mem PK</i>   |  | 34. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>ANNAPOLIS A.A. md</i>             |  |  |  |
| 35. FUNERAL DIRECTOR<br>NAME<br><i>Charles E. Hicks III</i>  |  | 36. ADDRESS<br><i>Annapolis Md.</i>   |  | 37. DATE REC'D. BY REGISTRAR<br><i>MAR 7 1984</i>  |  | 38. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Randall</i>                         |  |  |  |

MEDICAL CERTIFICATION

FOR

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BLACK

PERMANENT

U.S.A.

MA

Baltimore City

Baltimore Post-Record

Editorial

Wm. A. Bennett

MD

John Edgar

Editor

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1/2

133 E. Main St.

2-11-17 Baltimore Post-Record

Baltimore

133 E. Main St.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 4 5 2 3

REG. NO.

|   |  |  |  |   |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><i>Robert</i>  |  | MIDDLE<br><i>Thoms</i>  |  | LAST<br><i>Thoms</i>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>February 21, 1984</i> |  | 2b. HOUR<br><i>P</i>   |  |
| 3 SEX<br><i>Male</i>  |  | 4 RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 25 04</i>  |  | 6. AGE - (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>79</i>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                                  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Saint Agnes Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>U.S. Gov't</i>  |  |  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>---</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>525 N. Highland Ave. 21205</i>   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William Thoms</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Rosa Ehrman</i>  |  |   |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>216-05-4216</i>  |  | 17. INFORMANT ADDRESS<br><i>Ella Thoms 525 North Highland Ave 21205</i>   |  |   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>And myocardial infarction</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>---</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>---</i> |  |  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Seconds</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>---</i>   |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5</i> 19 <i>82</i> , to <i>2/21</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>10/23</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>D.W. MacDonald</i>   |  | DEGREE   |  | 22c. DATE SIGNED<br><i>2/22/84</i>  |  |   |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>D.W. MacDonald M.D.</i>   |  | 22e. ADDRESS<br><i>95. HIGHLAND AVE 21224</i>  |  |   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>2-25-84</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Sacred Heart Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Dundalk Balto. Co., Md.</i>                    |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles S. Zeiler &amp; Son Inc.</i>   |  | ADDRESS<br><i>901 S. Conkling St.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 23 1984</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randell</i>                                      |  |  |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                         |  |  |  |   |   |  |   | 4 5 2 4                                      |  |
|--|--|-------------------------|--|--|--|---|---|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |   |  |   | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Gordon R. Tillman</b>   |  |                         |  |  |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>2-19 1984</b>            |   | 2b. HOUR<br><b>6:30</b>  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>2</b> YEAR <b>57</b>                               |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>26</b> YRS.   |   | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |   | 7c. DATE PRONOUNCED DEAD<br><b>2-19 1984</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital-STU</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Robert</b> MIDDLE <b>Tillman</b> LAST <b>Tillman</b>   |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ruby</b> MIDDLE <b>Hale</b> LAST <b>Hale</b>  |  |  | 13e. STREET ADDRESS<br><b>21217 2342 Eutaw Place 3rd Floor</b>  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>  |  |                         | 16b. SOCIAL SECURITY NO.<br><b>040-64-9073</b>   |  |  | 17. INFORMANT<br><b>Catina Tillman</b>  |   |  | ADDRESS<br><b>2342 Eutaw Place 3rd fl 2212 Linden Avenue</b>                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wound of Abdomen (unspecified)</b><br>9654<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                         |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |                         |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOURS <b>11:20</b> P.M. MONTH <b>2</b> DAY <b>18</b> YEAR <b>1984</b> |  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject was shot</b>                             |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Tavern</b>                 |  |   |   | 21f. LOCATION<br>STREET <b>2360 Druid Hill Ave., Balto., Md.</b> CITY OR TOWN <b>Balton</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b> |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |  |  |   |   |  |   |  |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |   | MEDICAL EXAMINER<br>DATE SIGNED <b>2-19-84</b>   |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>  |  |                         |  | ADDRESS <b>111 Penn Street</b>   |  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  |                         | 23b. DATE<br><b>2/24/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Cemetery</b> |   |   | 23d. LOCATION<br>CITY OR TOWN <b>Chesterfield,</b> COUNTY <b>VA.</b> STATE <b>VA.</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |   |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Baby</b>   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 23 84</b>   |  | 2b. HOUR <b>2:36 PM</b>  |  |
| 3. SEX <b>MALE</b>   | 4. RACE <b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR <b>2 23 84</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>- - 18</b>                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES Hosp</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b> |
| 13a. STATE <b>Maryland</b>   |   | 13b. COUNTY <b>W -</b>  | 13c. CITY OR TOWN <b>Baltimore</b>                                       | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>George m Tippet</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tina Marie GILLIAM</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO. <b>N/A</b>   |  | 17. INFORMANT ADDRESS <b>George M. Tippet Same as # 13</b>                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Vascular collapse</b><br><b>7627</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chorio amnionitis</b>              |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                  |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE <b>W. Petst</b>   |   | DEGREE <b>MD</b>  |  | 22c. DATE SIGNED <b>2.23.84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. Petst M.D.</b>   |   | 22e. ADDRESS <b>St. Agnes Hospital, Baltimore, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |   | 23b. DATE <b>3/19/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>                                      |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD. 21229</b>  |   | 24. FUNERAL DIRECTOR <b>WITZKE FUNERAL HOME, CATONSVILLE, MD.</b>   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 and 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |                          |  |                                  |  |  |  |   | REG. NO.   |  |          |  |
|--|--|------------------------------|--------------------------|--|----------------------------------|--|--|--|---|--|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |                              |                          |  | 1. DECEASED NAME (TYPE OR PRINT) |  |  |  |   | 2a. DATE OF DEATH  |  | 2b. HOUR |  |
|  |  |                              |                          |  | JOHN TOTE                        |  |  |  |   | Feb 6 84   |  | 850 P.M. |  |
| 3. SEX   |  | 4. RACE                      |                          | 5. DATE OF BIRTH   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)            |  | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.   |  |          |  |
| Male   |  | White                        |                          | 2 2 06   |                                  | 78 82 YRS.                                 |  | MONTHS DAYS  |   | HOURS MIN.   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH       |  |  |   |  |  |          |  |
| W. Va.   |  | U. S. A.                     |                          |  |                                  | Baltimore City MD.                         |  |  |   |  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |                                  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |          |  |
| Baltimore  |  |                              |                          | Provident Hospital   |                                  |  |  | Coal Miner   |   |  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              | 13b. COUNTY              |  |                                  | 13c. CITY OR TOWN                          |  |  | 13d. INSIDE CITY LIMITS?  |  |  |          |  |
| Md.  |  |                              |                          |  |                                  | Balto.                                     |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |          |  |
| 14. FATHER'S NAME  |  |                              | 15. MOTHER'S MAIDEN NAME |  |                                  | 13e. STREET ADDRESS                        |  |  | 13f. ZIP CODE   |  |  |          |  |
| John   |  |                              | Mary                     |  |                                  | 591 S. Beechfield Ave., Balto., Md. #21229 |  |  |   |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                              | 16b. SOCIAL SECURITY NO. |  |                                  | 17. INFORMANT                              |  |  | ADDRESS   |  |  |          |  |
|  |  |                              | 236-10-2647              |  |                                  | Virginia Hoal                              |  |  | 591 S. Beechfield Ave., Balto., Md. #21229                          |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |                              |                          |  |                                  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |          |  |
| IMMEDIATE CAUSE (a) 0389 Sepsis - GI bleeding  |  |                              |                          |  |                                  |  |  |  |   |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory arrest  |  |                              |                          |  |                                  |  |  |  |   |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |                          |  |                                  |  |  |  |   |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |                          |  |                                  |  |  |  |   |  |  |          |  |
| 19a. DATE OF OPERATION   |  |                              |                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                  |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |          |  |
|  |  |                              |                          |  |                                  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |                          | 21b. TIME OF INJURY  |                                  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |          |  |
|  |  |                              |                          | HOUR A.M. MONTH DAY YEAR P.M. 19   |                                  |  |  |  |   |  |  |          |  |
| 21d. INJURY OCCURRED   |  |                              |                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                  |  |  | 21f. LOCATION  |   |  |  |          |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                              |                          |  |                                  |  |  | STREET CITY OR TOWN COUNTY STATE   |   |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 6/ 19 84, to Feb 6 19 84, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |                          |  |                                  |  |  |  |   |  |  |          |  |
| 22b. SIGNATURE   |  |                              |                          | DEGREE   |                                  |  |  | 22c. DATE SIGNED   |   |  |  |          |  |
| PM   |  |                              |                          | MD   |                                  |  |  | Feb 6/84   |   |  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |                          | 22e. ADDRESS   |                                  |  |  |  |   |  |  |          |  |
| ONY BUI  |  |                              |                          | 2600 Chelby Dr   |                                  |  |  |  |   |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |                          | 23b. DATE  |                                  | 23c. NAME OF CEMETERY OR CREMATORY         |  | 23d. LOCATION  |   | STATE  |  |          |  |
| Burial   |  |                              |                          | 2-9-84   |                                  | Glen Haven Cem.                            |  | Glen Burnie A.A.   |   | Md.  |  |          |  |
| 24. FUNERAL DIRECTOR   |  |                              |                          | 25a. DATE REC'D. BY REGISTRAR  |                                  |  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |  |          |  |
| G. Thomas Schwab 3512 Frederick Ave. #21229  |  |                              |                          | FEB 15 1984  |                                  |  |  | Julia Davidson-Randall   |   |  |  |          |  |

BP

100-100000

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[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]

FEB 15 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04527

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DAVID A. TOURANGEAU</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 16, 1984</b>                                 |  | 2b. HOUR<br><b>8:03 AM</b>                                      |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 20, 1960</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>23</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Warehouseman</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. CITY OR TOWN<br><b>Parkville</b>   |  |   |
| 13c. CITY OR TOWN<br><b>Parkville</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| 13e. STREET ADDRESS / ZIP CODE<br><b>24 Class Court 21234</b>  |  |   |   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur P Tourangeau</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pamela Martin</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>185-46-2459</b>  |   | 17. INFORMANT<br><b>Mr Arthur P Tourangeau</b>                                       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>2706</b> IMMEDIATE CAUSE (a) <b>Brain Death</b>   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hyperammonemia, unclear etiology</b>   |   | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute lymphocytic leukemia</b>              |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/16</b> 19 <b>84</b> to <b>2/16</b> 19 <b>84</b> that (I) (we) (we) saw the deceased alive on <b>2/16</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Andrew Blamer MD</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2/16/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDREW BEAMER</b>  |  | 22e. ADDRESS<br><b>600 N. WOLFE ST. - BALTO. 05, MD</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/20/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem Park</b>                       |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1984</b>   |   |  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendall</b>  |  |   |   |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please reattach this certificate, with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, then medical examiner must be notified at once.

FILED

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RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

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1/2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GEORGE L. TOWNSEND   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 17 84   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 24 05  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2616 OSWEGO AVENUE  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Peter Townsend  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Haroldanna  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>248-68-3705  |  |
| 17. INFORMANT<br>ADDRESS<br>Maggie Jones 2616 Oswego Avenue   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>4149<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Ischemic Heart Disease</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 6, 19 84</u> , to <u>February 17, 19 84</u> , that (I) (we) last saw the deceased alive on <u>2/17/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>M. Jameson</u>   |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>2/20/84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>M. JAMESON</u>  |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>   |  | 23b. DATE<br><u>2/23/84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Auburn Cem.</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Md.</u>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Wm C March F/H Inc.</u>  |  | ADDRESS<br><u>1101 E North Avenue</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 21 1984</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson</u>   |  |

MEDICAL CERTIFICATION

OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF NEW YORK

IN SENATE  
January 10, 1907  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 10, 1906

ALBANY:  
J. B. LIPPINCOTT & CO.,  
PRINTERS,  
1907.

NEW YORK:  
J. B. LIPPINCOTT & CO.,  
PRINTERS,  
1907.



CHIEF CLERK

PC&COT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))

20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |                 |                |   |  |                   |  |   |                |  |  |   |  |  |                        |   |  |  |  |  |  |  |  |
|---|--|-----------------|----------------|---|--|-------------------|--|---|----------------|--|--|---|--|--|------------------------|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                 | FIRST<br>EMORY |   |  | MIDDLE<br>CLINTON |  |   | LAST<br>TRACEY |  |  | 20. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>2 9 1984   |  |  | 2b. HOUR<br>M<br>10:55 |   |  |  |  |  |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White |                | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 4, 1906   |  |                   | 6 AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>77 YRS. |   |                | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN. |  |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 9 1984 |  |                        | 7d. HOUR<br>M<br>10:55                            |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                 |                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |                        |   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                 |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital (STU) |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver   |                |  |  | 12b. KIND OF BUSINESS<br>Country Highway Dep  |  |  |                        |   |  |  |  |  |  |  |  |
| 13a. STATE<br>Maryland  |  |                 |                | 13b. COUNTY<br>Baltimore  |  |                   |  | 13c. CITY OR TOWN<br>Sparks   |                |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |                        | 13e. STREET ADDRESS<br>2200 Benson Mill Rd. 21152 |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Tracey   |  |                 |                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Wisner  |  |                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No  |                |  |  |   |  |  |                        | 16b. SOCIAL SECURITY NO.<br>215-18-3115           |  |  |  | 17. INFORMANT<br>ADDRESS<br>Evna Rd.<br>Marian L. Seipp, Parkton, MD 21120 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <u>Gunshot wound to head (rifle)</u><br>9552<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b).<br>(c).  |  |                 |                |   |  |                   |  |   |                |  |  |   |  |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                 |                |   |  |                   |  |   |                |  |  |   |  |  |                        |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                 |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                   |  |   |                |  |  |   |  | 20. AUTOPSY?<br>Head Only<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        |   |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                 |                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>9:30 AM 2-9-1984   |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Self-inflicted.  |                |  |  |   |  |  |                        |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |                 |                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>chicken coup   |  |                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2200 Benson Mill Rd. Balto. Md.  |                |  |  |   |  |  |                        |   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                 |                |   |  |                   |  |   |                |  |  |   |  |  |                        |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                 |                | TITLE (SPECIFY)<br>M.D. Assistant   |  |                   |  | MEDICAL EXAMINER  |                |  |  | DATE SIGNED 2-9-84  |  |  |                        |   |  |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |                 |                | ADDRESS 111 Penn St., Balto., Md. 21201   |  |                   |  |   |                |  |  |   |  |  |                        |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                 |                | 23b. DATE<br>Feb. 13, 1984  |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Grove Cemetery  |                |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkton, Baltimore, Md.                           |  |  |                        |   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. U. Hartenstein   |  |                 |                | ADDRESS<br>New Freedom, PA 17349  |  |                   |  | 25. DATE RECEIVED<br>FEB 15 1984  |                |  |  | 26. SIGNATURE<br>   |  |  |                        |   |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04530

REG. NO.

|  |  |   |   |   |  |   |  |   |  |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hazel Irene Tucker  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 10 1984 |   |  | 2b. HOUR<br>05:30 AM  |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 8 1906  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6225 York Road |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerical                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Pharmacy                                 |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |   | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6225 York Rd. 21212                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George S. Lopez  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Harritt Drury  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |   | 16b. SOCIAL SECURITY NO.<br>215-03-2518   |  | 17. INFORMANT<br>ADDRESS<br>Judith T. Hart Towson, Md.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>4920<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Emphysema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cigarette Smoking</u>   |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 <u>in</u><br>years<br>years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Right Sided Heart Failure</u>   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-6</u> , 19 <u>80</u> , to <u>11-10</u> , 19 <u>84</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>11-9</u> , 19 <u>84</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <u>viewed</u> the body after death. |  |   |   |   |  |   |  |   |  |
| 23a. SIGNATURE<br><u>Joseph W. Zebley</u>  |  |   |   |   |  | DEGREE<br>M.D.  |  | 23c. DATE SIGNED<br><u>11-10-84</u>   |  |
| 23b. PHYSICIAN'S NAME (PRINT)<br>Joseph W. Zebley  |  |   |   |   |  | 23d. ADDRESS<br>3809 Greenmount Ave., Balto., Md.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2-13-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co., Balto., Md.   |  |   |   |   |  | 25a. EC'D. BY REGISTRAR<br>FEB 10 1984  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARGARET MIDDLE Spear LAST Tucker   |  |   |  | FEB. 18 1984 1020 A.M.   |  |  |  |
| 2. SEX Female  |  | 4. RACE Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR July 14, 1913  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Packer   |  | 12b. KIND OF BUSINESS OR INDUSTRY Retail Sales   |  |
| 13a. STATE Maryland  |  | 13b. CITY OR TOWN Baltimore   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS 1235 Harwall Road 21207  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel Barnes  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Mae Kelso  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. N/A  |  | 17. INFORMANT ADDRESS Mr. Harold E. Tucker Same as # 13  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4310 INTRACEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO, OR AS A CONSEQUENCE OF (c) } |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (my) (this hospital) attended the deceased from FEB 6, 19 84, to FEB 18, 19 84, that (we) (we) lost saw the deceased alive on FEB 18, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |   |  |  |  |  |  |
| 22b. SIGNATURE Bert F. Morton M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |  | 22c. DATE SIGNED FEB 18, 1984  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERT F. MORTON   |  |   |  | 22e. ADDRESS St. Agnes Hospital Balt, Md 21229   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 2/21/84   |  | 23c. NAME OF CEMETERY OR CREMATORY Lake View Mem Pk  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll, Md.  |  |
| 24. FUNERAL DIRECTOR NAME MacNabb Funeral Home   |  |   |  | 25a. DATE REC'D. BY REGISTRAR FEB 21 1984  |  |  |  |
| ADDRESS Catonsville, Md.   |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event (the medical examiner must be notified at once).

## MEDICAL CERTIFICATION

| Item 13athur e 3-6-84 cn   |  |   |  | STATE OF MARYLAND  |  | 04532   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SARAH TULL  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-29-84 |  |  | 2b. HOUR<br>5 <sup>35</sup> PM  |  |
| 3. SEX<br>FEMALE   | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-4-38   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ATLANTIC, VA.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CITY HOSP. |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |   |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13c. STREET ADDRESS / ZIP CODE<br>ATLANTIC, VA. Rural 21199   |  |
| 14. FATHER'S NAME<br>FIRST MORGAN MIDDLE WILLIAM LAST AMY  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST BERNICE MIDDLE MILLER LAST  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>230 48 1510   |  | 17. INFORMANT ADDRESS<br>CALVIN TULL ATLANTIC, VA. 23303   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>0389<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEPSIS AND RENAL FAILURE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-27, 1984, to 2-29, 1984, that (I) (we) lost saw the deceased alive on 2-29, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Francis J. Collini   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2-29-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANCIS J. COLLINI  |  | 22e. ADDRESS  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3/4/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SHILOH BAP. CEM.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ATLANTIC, VA.   |  |
| 24. FUNERAL DIRECTOR<br>NAME LEROY O. DYETT 4600 LIBERTY HGTS. AVE.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

04533

|   |         |   |   |   |  |  |
|---|---------|---|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |         | 2a. DATE OF DEATH   |   | 2b. HOUR  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | MONTH DAY YEAR  |   | MONTH DAY YEAR  |  |  |
| OTIS CRANSTON TYLER   |         | 02 13 84  |   | 3 PM  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)   | 7. IF UNDER 1 YEAR  |  |  |
| M   | W       | MONTH DAY YEAR  | 44  | MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |  |
| MD  |         | USA   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT CITY MD.   |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |
| BALT CITY   |         | UNIVERSITY OF MD HOSPITAL   |   | STATE TROOPER   |  |  |
| 13a. STATE  |         | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  |  |  |
| MD  |         | TALBOT  | EASTON  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  |
| FIRST MIDDLE LAST   |         | FIRST MIDDLE LAST   |   | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |
| LLOYD S TYLER   |         | DOROTHY G Tyler   |   | YES 1959-1963 216-38-9421   |  |  |
| 17. INFORMANT   |         | ADDRESS   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |
| WIFE  |         | RD1 Box 240   |   | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Embolism - Respiratory Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>2396</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>CARDIAC ARREST</i> |  |  |
| 19. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?   |  |  |
| 2/17/84   |         | Brain Tumor   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/5</i> , 19 <i>84</i> , to <i>2/13</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>2/13</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         | 22b. SIGNATURE<br><i>J Parkinson</i> MD<br>DEGREE   |   | 22c. DATE SIGNED<br><i>2/13/84</i>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |         | 22e. ADDRESS  |   | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |
| J PARKINSON MD  |         | UNIV of MD HOSPITAL   |   | Burial  |  |  |
| 23b. DATE   |         | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |
| 2-17-84   |         | Oxford, Cemetery  |   | Oxford Talbot MD.   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |         | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR   |  |  |
| Newnam Funeral Home, P.A.   |         | Easton  |   | FEB 16 1984   |  |  |
| 25b. REGISTRAR'S SIGNATURE  |         | 25c. REGISTRAR'S SIGNATURE  |   | 25d. REGISTRAR'S SIGNATURE  |  |  |
| <i>Davidson-Randall</i>   |         | <i>Davidson-Randall</i>   |   | <i>Davidson-Randall</i>   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

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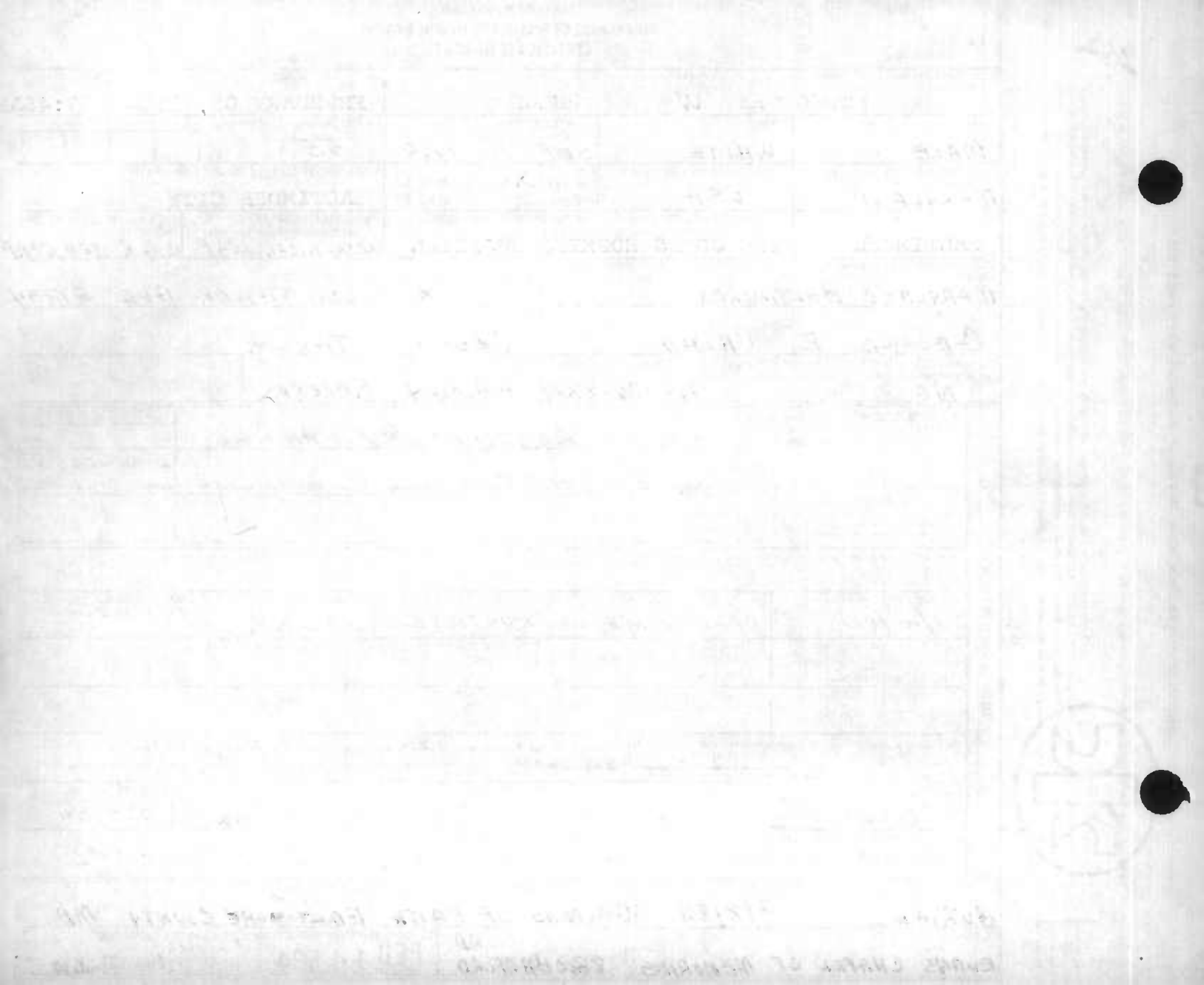
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 04534   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THEODORE W. UHLAN</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 05, 1984</b>   |  | 2b. HOUR<br><b>07:45AM</b>   |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEP 10 1928</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MECHANICAL INSP.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>C.G.R. MED. CORP.</b>  |   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE E. UHLAN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JESSIE TAYLOR</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |   |
| 16b. SOCIAL SECURITY NO.<br><b>213-26-8229</b>  |  | 17. INFORMANT<br><b>FAMILY RECORDS</b>   |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC PROSTATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DIAGNOSED 4 MONTHS AGO</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>1/10/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA OF PROSTATE</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1.8</b> , 19 <b>84</b> , to <b>2.5</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2.5</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>ANUP KUMAR SINGH</b>   |  |  |  | DEGREE<br><b>M.B.B.S., F.R.C.S.</b>   |  | 22c. DATE SIGNED<br><b>2.5.84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANUP KUMAR SINGH</b>  |  |  |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2/8/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY MD.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES 8800 HARFORD RD.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>A. Anderson-Randall</b>   |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

04535

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--------------------------------------|--|--|------------------|--|--|--------------------------|--|--|-------|--|--|----------|--|--|-------|--|--|----------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST  |  |  | MIDDLE  |  |  | LAST   |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED |  |  | MONTH            |  |  | DAY                      |  |  | YEAR  |  |  | 2b. HOUR |  |  |       |  |  |          |  |  |
| Unknown # 84-20   |  |  |  |  |  |   |  |  |  |  |  | X                                    |  |  | 2                |  |  | 25                       |  |  | 19 84 |  |  | M        |  |  |       |  |  |          |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  | IF UNDER 1 YR.                       |  |  | IF UNDER 24 HRS. |  |  | 7c. DATE PRONOUNCED DEAD |  |  | MONTH |  |  | DAY      |  |  | YEAR  |  |  | 2d. HOUR |  |  |
| Male  |  |  | Black  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  | 2     |  |  | 25       |  |  | 19 84 |  |  | 2:50A M  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| Baltimore   |  |  |  |  |  |   |  |  | Baltimore City,  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| Baltimore   |  |  | 1100 Blk. Edison Hwy.  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 13a. STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS                  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |  | ADDRESS  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| Unkn.   |  |  |  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple injuries</u><br>9571<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____   |  |  |  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  | 20. AUTOPSY?  |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
|   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 2 1984   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
|   |  |  |  |  |  | Subject jumped from bridge  |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street                                      |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1100 Blk. Edison Hwy, Balto. Md.   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| ACTUAL SIGNATURE  |  |  | TITLE (SPECIFY)  |  |  | DATE SIGNED   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| Thomas D. Smith   |  |  | M.D. Deputy Chief  |  |  | 2/25/84   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  | ADDRESS  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| Thomas D. Smith, M.D.   |  |  | 111 Penn St. Balto., MD.   |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| Removal   |  |  | 4/17/84  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |
| Anatomy Board   |  |  | Balto., Md.  |  |  |   |  |  |  |  |  |                                      |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |       |  |  |          |  |  |

MAR 19 1984

BALTIMORE, MD.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | REG. NO.  |  |  |   |   |
|---|--|--|--|---|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Catherine Mary Valentine   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 4 1984   |  |  |   | 2b. HOUR<br>M                                   |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 23, 1904   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13e. STREET ADDRESS<br>214 West 27th St 21211                                  |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ethan Daniel Nolan  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Bayley                                    |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>No  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>214-07-0088 B   |  | 17. INFORMANT<br>ADDRESS<br>Mr John R Valentine 323 Endsleigh Ave  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Respiratory Arrest<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hypertensive Cardiovascular Disease 10 years |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |  |   |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1981 to Jan 1984, that (I) (we) lost<br>saw the deceased alive on Jan 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |   |  |  |   |   |
| 22b. SIGNATURE<br>Adoracion B. Paulino  |  |  |  |   | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/5/84                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Adoracion Paulino M.D.   |  |  |  |   | 22e. ADDRESS<br>Baltimore, Maryland<br>Medical Arts Bldg. XXXXXXXX                              |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>2/7/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J Ruck Inc. Baltimore, Maryland   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br>Feb 7 1984 [Signature]   |   |   |

BP

RECEIVED  
NAVY DEPARTMENT  
WASHINGTON, D.C.



and



Parkway

27124

1918

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>William p. Valentine |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 11, 1984 |   |  | 2b. HOUR<br>5:00A M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 14 14  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br>69   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>Clarence Valentine                                       |  |  |   | 15. MOTHER'S MAIDEN NAME<br>Della Ballard   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>705-14-0672  |   | 17. INFORMANT ADDRESS<br>Irvin Valentine 3824 Roland View Ave.  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4275 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Anoxic Encephalopathy, Malnutrition, possible Carcinoma, Cerebrovascular Infarction

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 8, 19 84 to February 11, 19 84, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on February 11, 19 84, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>D. Boston  |  | DEGRBE<br>mB   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/11/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J Boston  |  | 22e. ADDRESS<br>c/o Maryland General Hospital                          |  |  |  |   |  |

|   |  |                      |  |  |  |   |  |
|---|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                       |  | 23b. DATE<br>2/15/84 |  | 23c. NAME OF CEMETERY<br>Garrison Veteran VA |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills, Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C Macch F/H Inc. 1101 E North Avenue |  |                      |  | 25a. DATE OF REGISTRATION<br>FEB 14 1984     |  | 25b. SIGNATURE<br>John Davidson-Randall                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Washington, D.C. 20540

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FREDERIC J. VAUGHAN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 2, 1984</b>   |   |  | 2b. HOUR<br>MIN. AM PM<br><b>4:06 AM</b>  |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 6, 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>70</b>                                |   | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Warehouse</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Warehouse</b>             |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>701 Venable Ave. 21218</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Vaughan</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Inez Edish</b>   |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17. INFORMANT<br><b>Mrs. Margaret Sams, Balto., MD</b>  |  | ADDRESS   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>2030</b><br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST SECONDARY TO</b><br><b>ATRIAL ARRHYTHMIA, CONGESTIVE HEART FAILURE / PLASMA CELL</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYELOMA, PLASMA CELL LEUKEMIA, HYPER-CALCEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERCALCEMIA, RENAL FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>HYPERCALCEMIA, RENAL FAILURE</b>  |  |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>2/1/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>HEMODIALYSIS FOR RENAL FAILURE</b>   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> , 19 <b>84</b> , to <b>2/2</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>M. Keith Lawrence</b>   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>2/2/84</b>   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAWLINS</b>  |  |   | 22e. ADDRESS<br><b>201 EAST UNIVERSITY PARKWAY</b>   |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2/3/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., MD 21212</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 6 1984</b>   |  |   |   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |   |  |   |  |   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For a certificate to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

Handwritten notes and stamps, including "FEDERAL BUREAU OF INVESTIGATION" and "U.S. DEPARTMENT OF JUSTICE".

501 N. W. 11th St. Miami, Fla. 17  
JAN 17 1964  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: This form required for the death certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove the bottom section of the certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |                                    |   |  |   |
|--|--|--|---|--|------------------------------------|---|--|---|
| 1. DECEASED NAME<br>(Type or Print)  |  |  | 2a. DATE OF DEATH   |  |                                    | 2b. HOUR  |  |   |
| ALEX C. VAWRYK   |  |  | FEBRUARY 3, 1984  |  |                                    | 2:30 M  |  |   |
| 3. SEX   |  |  | 4. RACE   |  |                                    | 5. DATE OF BIRTH  |  |   |
| Male   |  |  | White   |  |                                    | 8 4 1916  |  |   |
| 7a. BIRTHPLACE<br>(State or Foreign Country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |
| Pennsylvania   |  |  | U.S.A.  |  |                                    | BALTIMORE CITY MD.  |  |   |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(If not in such facility, give street address) |  |                                    | 12a. USUAL OCCUPATION<br>(Type of work for most of working life)  |  |   |
| BALTIMORE  |  |  | THE JOHNS HOPKINS HOSPITAL  |  |                                    | Welder  |  |   |
| 13a. STATE   |  |  | 13b. COUNTY   |  |                                    | 13c. CITY OR TOWN   |  |   |
| Maryland   |  |  | Baltimore   |  |                                    | Dundalk   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |                                    | 16. ADDRESS   |  |   |
| Dimetro Vawryk   |  |  | Dorothy Mitchell  |  |                                    | 7648 Old Battle Grove Rd.   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |                                    | 17. INFORMANT   |  |   |
| Yes  |  |  | WW II   |  |                                    | Richard E. Jerome Balto. MD 21222   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |                                    |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |
| 5189 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST  |  |  |   |  |                                    |   |  | 10 MINUTES  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                    |   |  | 6 hours   |
| (b) HYPOTENSION  |  |  |   |  |                                    |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                    |   |  | 34 DAYS   |
| (c) GASTRO INTESTINAL bleed  |  |  |   |  |                                    |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |  |                                    |   |  |   |
| METASTATIC Squamous Cell Carcinoma of Left Maxillary Sinus   |  |  |   |  |                                    |   |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                    | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |
|  |  |  |   |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |                                    | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |
|  |  |  | P.M. 19   |  |                                    |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
|  |  |  |   |  |                                    |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22, 19 84, to 2/3, 19 84, that (I) (we) lost<br>saw the deceased alive on 2/3, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                    |   |  | 22c. DATE SIGNED  |
| 22b. SIGNATURE   |  |  |   |  |                                    |   |  | 22c. DATE SIGNED  |
| Rafael R. Portela  |  |  |   |  |                                    |   |  | 2/3/84  |
| 22d. PHYSICIAN'S NAME (Type or Print)  |  |  |   |  |                                    | 22e. ADDRESS  |  |   |
| RAFAEL R. PORTELA  |  |  |   |  |                                    | 600 N. WOLFE ST. BALTO. 21205, MD.  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |
| Cremation  |  |  | 2/6/84  |  | Westview                           |   | Baltimore Maryland                         |   |
| 24. FUNERAL DIRECTOR   |  |  |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |
| Duda-Ruck, Inc.<br>7922 Wise Avenue, Dundalk, MD 21222   |  |  |   |  |                                    | FEB 7 1984  |  | John J. Conner  |

BP





BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| FOR<br>1- STATE<br>REGISTRAR   |                         | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |   |   |   |  |  |   |  | REG. NO. 4540 |  |
|--|-------------------------|--|--|---|---|---|---|--|--|---|--|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES W. VEAZEY JR.</b>   |                         |  |  |   |   | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR <input checked="" type="checkbox"/> 2-29-84 |   |  |  | 2b. HOUR OF DEATH   |  |               |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 22 1924</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>59 YRS.</b>                           | 7. IF UNDER 1 YR.<br>MONTHS DAYS  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   |   | 9. DATE PRONOUNCED DEAD<br><b>3-1-84</b>   |  | 9. HOUR OF DEATH<br><b>1:45P</b>  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> |  |  |   |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1214 N. Stricker Street</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |               |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   | 13e. STREET ADDRESS<br><b>1214 N. Stricker Street</b>  |  |   |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles W. Veazey, Sr.</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carolyn Hilton</b>      |   |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b> |  |   |  |               |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-14-8587</b>   |                         |  |  | 17. INFORMANT ADDRESS<br><b>Evangeline Dawson 7312 Fairbrook Rd Apt. 1A</b> |   |   |   |  |  |   |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |                         |  |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |                         |  |  |   |   |   |   |  |  |   |  |               |  |
| 19a. DATE OF OPERATION   |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |   |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                               |   |  |  |   |  |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                 |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |               |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |   |   |   |  |  |   |  |               |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |                         |  |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>                                    |   |   |   | DATE SIGNED <b>3-2-84</b>  |  |   |  |               |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |                         |  |  | ADDRESS <b>111 Penn Street</b>  |   |   |   |  |  |   |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |                         | 23b. DATE<br><b>3/6/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forrest V.A. Cem.</b>     |   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills, Md.</b>   |  |   |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H, Inc. 1101 E. North Ave</b>  |                         |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 05 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>  |  |   |  |               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal officer must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>(BABY GIRL) JEWELYN LAKEISHA LYNN FOSTER</b>   |  |   |  | MONTH DAY YEAR<br><b>2 23 84</b>   |  | 2b. HOUR<br><b>8:55 P.M.</b>   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 23 84</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>8 8</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITALS</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1312 Kenwood Ave. 21213</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Anthony J. Vereen</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Jewel Foster</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Margaret Foster 2228 E. Oliver St.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fetal Asphyxia</b><br>7701<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Meconium Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> , 19 <b>84</b> , to <b>2/23</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2/23</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Richard A. Molteni</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 22c. DATE SIGNED<br><b>2/23/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD A. MOLTENI</b>  |  |   |  | 22e. ADDRESS<br><b>BALTIMORE CITY HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/1/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C March F/H Inc, 1101 E North Avenue</b>   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 26 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Shirley Davidson-Randall</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the city health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified or called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Louis Charles Vogel</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-6-84</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  |   |  | 2b. HOUR<br><b>2:26 AM</b>   |  |   |  |
| 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 13 99</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hosp.</b>                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CAN COMPANY</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Balto.</b>  |  | 13c. STREET ADDRESS / ZIP CODE<br><b>5075. Fulton Ave. 21223</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles Vogel</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Isabelle Parley</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW I</b>                            |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-07-2467</b>  |  | 17. ADDRESS<br><b>LOUIS H. VOGEL 2608 JERALD DRIVE, 21234</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>4415</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO AORTIC Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Smoking</b> |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>-</b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/10/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ARTERIO AORTIC Atherosclerosis</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. - 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b>   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>-</b>  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> , 19 <b>84</b> , to <b>2/6</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2/6</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Lion M. Rologues</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/6/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LEON M. RALOGUES</b>  |  | 22e. ADDRESS<br><b>BON SECOURS HOSPITAL</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>02-08-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Sam J. Smith</b>   |  |

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1. The first part of the document  
 discusses the general principles of  
 the project and the objectives of the  
 study. It also mentions the scope of the  
 work and the limitations of the study.  
 2. The second part of the document  
 describes the methodology used in the  
 study. It includes details about the data  
 collection methods, the sample size, and  
 the statistical analysis techniques used.  
 3. The third part of the document  
 presents the results of the study. It  
 includes tables and figures that illustrate  
 the findings of the research.  
 4. The fourth part of the document  
 discusses the conclusions of the study and  
 the implications of the findings. It also  
 mentions the limitations of the study and  
 suggests areas for future research.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04543

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |
|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAM T WADE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>9</b> YEAR <b>84</b> 2b. HOUR <b>216</b> AM |   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>30</b> YEAR <b>10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>BALT.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV OF MD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF LAST YEAR)<br><b>Shearman</b>       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel</b>  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY<br><b>CITY</b>   | 13c. CITY OR TOWN<br><b>BAL</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 14. FATHER'S NAME<br>FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>WADE</b> LAST <b>WADE</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-5299</b>  |  | 17. INFORMANT<br><b>Geneva Wade</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULM ARREST</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CANCER</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>NA</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>NA</b>   |  |   |  |   |
| 19a. DATE OF OPERATION<br><b>NA</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 16</b> , 19 <b>84</b> , to <b>FEB 9</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>21 9 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |
| 22b. SIGNATURE<br><b>Harry A. Oker MD</b>  | DEGREE   |   | 22c. DATE SIGNED<br><b>2/9/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HARRY OKER MD</b>  | 22e. ADDRESS<br><b>Univ of Md Hosp</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   | 23b. DATE<br><b>2/13/1984</b>  | 23c. NAME OF CEMETERY OR CREMATOR<br><b>Arbutus Memorial Park</b>   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE            |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Nutter &amp; Sons</b> ADDRESS <b>2501 Gwynns Falls Pkwy</b>  |  | DATE REC'D. BY REGISTRAR<br><b>FEB 14 1984</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Rendell</b>  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Request may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

INDEX

10/1/84

10/1/84  
1000 Wildwood  
Bkwy, Baltimore, Maryland 21229

1000 Wildwood Parkway 21229  
Baltimore, Maryland

Funeral Home Inc. Baltimore, Maryland 21218  
N. Lee & Sons 2501 Geneva Falls Hwy.  
Baltimore, Maryland 21218



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
|---|--|--|--|---|--|-----------------------------------|--|--------------------------|--|------------------|--|--------------------------------------|--|-------|--|------|--|--|--|------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST                              |  | 2a. DATE OF DEATH        |  | KNOWN ESTIMATED  |  | MONTH                                |  | DAY   |  | YEAR |  | 2b. HOUR                                     |  |            |  |
| MARY  |  | E.   |  | WAKE  |  |                                   |  | 2                        |  | 5                |  | 19                                   |  | 84    |  |      |  | M  |  |            |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                 |  | IF UNDER 1 YR.           |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY  |  | YEAR   |  | 2d. HOUR   |  |
| Female  |  | Black  |  | 8 28 24   |  | 59 YRS.                           |  |                          |  |                  |  | 2                                    |  | 5     |  | 19   |  | 84   |  | 12:05 a.m. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED                     |  | WIDOWED                  |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |      |  |  |  |            |  |
| Maryland  |  | U.S.A.   |  |   |  |                                   |  |                          |  |                  |  | Baltimore City MD                    |  |       |  |      |  |  |  |            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| Baltimore   |  | Church Hospital  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS      |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| Maryland  |  |  |  | Baltimore   |  | YES XX NO                         |  | 319 S. Herring Ct. 21231 |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| George  |  | Gertrude   |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS                           |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| UNKNOWN   |  | N/A  |  | Gloria Edmonds  |  | 319 S. Herring Ct.                |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |            |  |
| PART I DEATH WAS CAUSED BY:   |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| IMMEDIATE CAUSE (a) <u>Metastatic pelvic carcinoma</u>  |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 1991  |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:   |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| (b) _____   |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| (c) _____   |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                           |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  | 20. AUTOPSY?                                 |  |            |  |
|   |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  | Partial YES X NO                             |  |            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED                                      |  | 21d. LOCATION                     |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | P.M. 19   |  | CITY OR TOWN COUNTY STATE         |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | Partial                           |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
|   |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner |  |  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)  |  | DATE SIGNED   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
|   |  | M.D. Assistant   |  | 2-5-84  |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| Ann M. Dixon, M.D.  |  | 111 Penn St., Balto., Md. 21201  |  |   |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                            |  | 23d. LOCATION                     |  | 23e. STATE               |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| BURIAL  |  | 2/10/84  |  | Balto. National Cem.  |  | Baltimore, Md.                    |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                    |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |
| Wm C March F/H Inc.   |  | FEB 7 1984   |  | John J. Connel  |  |                                   |  |                          |  |                  |  |                                      |  |       |  |      |  |  |  |            |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04545

1- FOR  
STATE  
REGISTRAR

REG. NO.

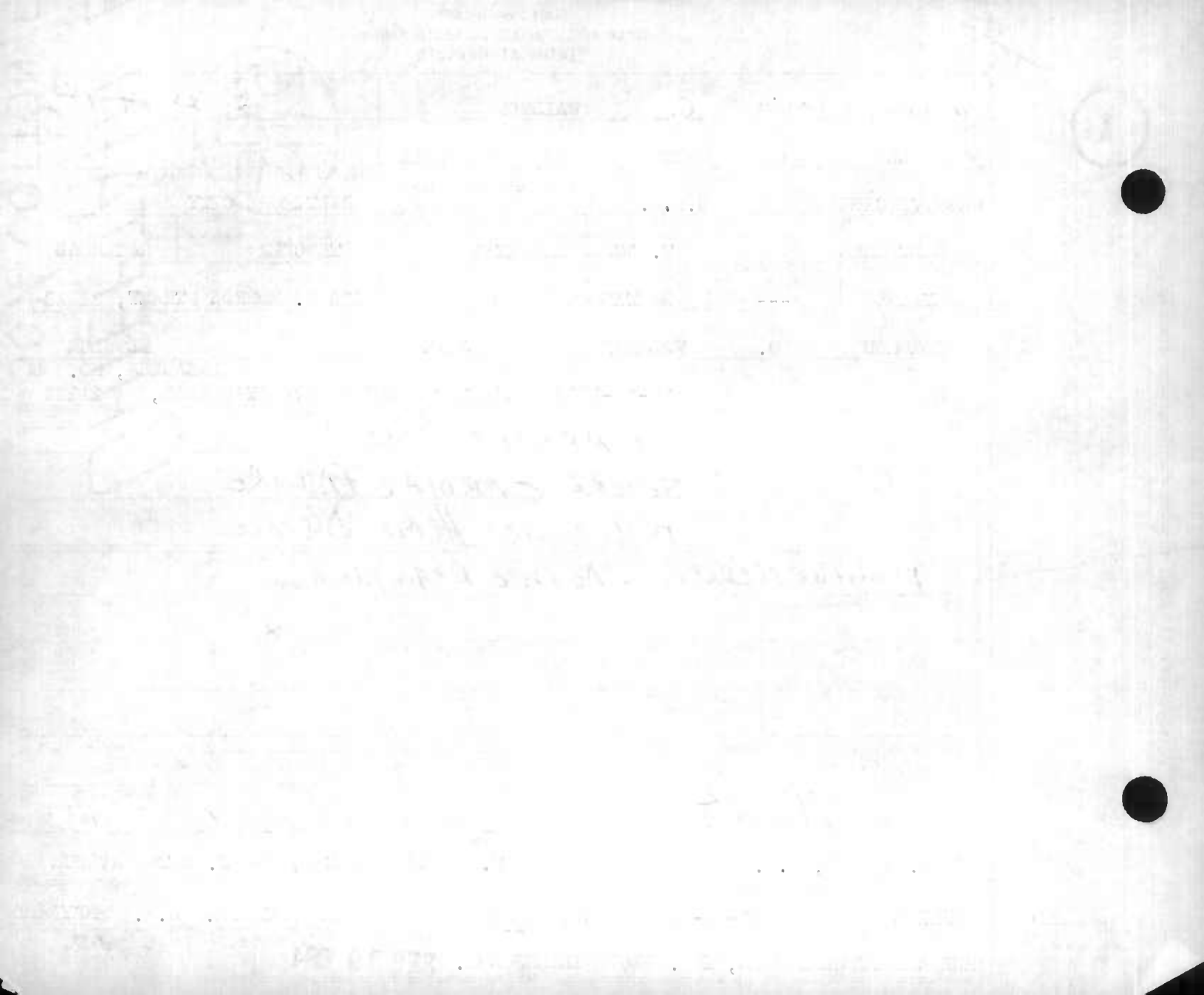
|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DAVID OWEN WALDRON  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 25 84 |   |  | 2b. HOUR<br>1:00 A.M.  |  |
| 3 SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 21 11  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WEST VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TRUCKER  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>RAILROAD  |  |   |  |   |  |  |  |
| 13a. STATE<br>MARYLAND   |  |   |  |   |  |  |  |
| 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>624 S. MONROE STREET, 21223   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SOLOMON O. WALDRON   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JANE KESSLER   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>232-22-1730  |  | 17. INFORMANT<br>ADDRESS PASADENA, MD.<br>LEONARD WALDRON 179 RYAN ROAD, 21122  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEVERE CARDIAC FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ISCHEMIC HEART DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes Mellitus - Aortic Regurgitation</u>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>M. Elmour</u><br>M. ELNOUR, M.D.   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>2/25/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. ELNOUR, M.D.   |  |   |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL, 900 S. CATON AVENUE   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>02-28-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BROOKLYN PK. A.A. MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.   |  |   |  | ADDRESS<br>21229 4107 WILKENS AVE.  |  | DATE RECEIVED BY REGISTRAR<br>FEB 29 1984  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please forward to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>George A. Walker Jr.  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 19, 1984   |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 17 23  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Vocat Rehab Counselor  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Vocat. Rehab   |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>1  |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George A Walker Sr.  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Grace B. Stiff  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>220-14-9218   |  | 17. INFORMANT ADDRESS<br>GRACE M. KULP 1104 BEACH PROMENADE   |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Liver failure<br>5715 DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cirrhosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Multiple Transfusions, Secondary to hemophilia A<br>54 years diagnosed 1937 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Renal failure  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/29, 1983, to 2/19, 1984, that (I) (we) last saw the deceased alive on 2/19, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.) |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Charles L. Stevens MD   |  | 22c. DATE SIGNED<br>2/19/84   |  |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LAZIN  |  |
| 22e. ADDRESS<br>1501 E. Fort Ave. & Hull St. 21230  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>2/23/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GLEN HAYEN CEM.   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Gov. Ritchie Hwy GLEN BURGIE MD.   |  | 24. FUNERAL DIRECTOR<br>NAME<br>CHARLES L. Stevens Funeral Home Inc.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>P. Davidson-Randall   |  |

BP

RECEIVED  
JAN 10 1912

Dear Sir,  
I have the pleasure to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.  
The same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
[Signature]

Very truly yours,  
[Signature]  
[Title]

Very truly yours,  
[Signature]  
[Title]



PAID IN ADVANCE

2025-00-00-00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

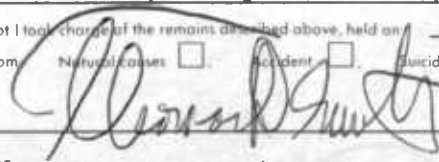

BP \_\_\_\_\_

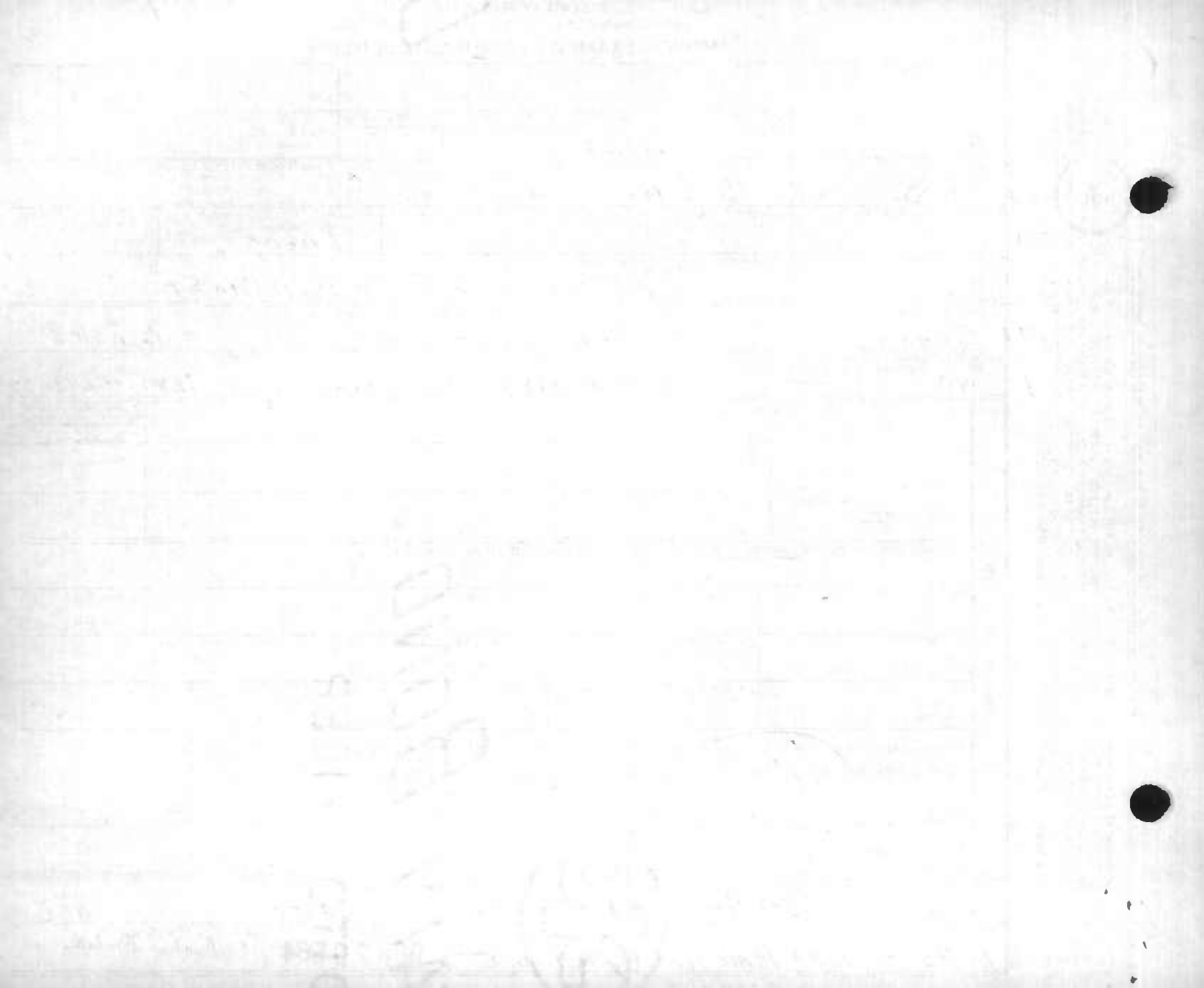
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(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                         |  |  |   |   |   |   |  |
|---|-------------------------|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John Walker</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>2 25 19 84</b>                         |   |   | 2b. HOUR<br>M<br><b>6:35P</b>   |   |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 21 61</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>22 YRS.</b>                                   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2 25 19 84</b>   | 2d. HOUR<br>M<br><b>6:35P</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>M.D.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Labor</b>                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                                       |  |
| 13a. STATE<br><b>M.D.</b>   |                         |  | 13b. COUNTY<br><b>—</b>  | 13c. CITY OR TOWN<br><b>BAITO.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1285. Hilton St. #229</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Walker</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Geneva Gingles</b>                 |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>219-78-8218</b>   |   | 17. INFORMANT ADDRESS<br><b>MRS. Geneva Gingles 1285. Hilton St</b>                             |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stab wound of chest</b><br><b>9660</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>(c) _____  |                         |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).)   |                         |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                      |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>5:42 AM 2 25 84</b>   |                         |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>5:42 AM 2 25 84</b>                   |   |   |   |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject stabbed</b>   |                         |  |  |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Lexington Market</b> |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>400 W. Lexington St., Balto. Md.</b>                        |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from _____ Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br>  |                         |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>   |   |   | DATE SIGNED<br><b>2/26/84</b>   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                         |  | ADDRESS<br><b>111 Penn St. Balto., MD.</b>   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         |  | 23b. DATE<br><b>3-3-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BAITO. Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BAITO. MD.</b>                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Betts Funeral Home 1129 N. Caroline St.</b>  |                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 29 1984</b>                                    |   |   | 25b. REGISTRAR'S SIGNATURE<br> |   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04548

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary E. WALLACE</b>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 22, 1984</b>                                    |  | 2b. HOUR<br><b>5:20P<sub>M</sub></b>  |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 24 36</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |   |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1510 Brentwood Ave. 21202</b>                                     |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Wallace</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Irene Durham</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>Carolyn Stanley 2425 Shirley Avenue</b>                                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>Bronchopneumonia and Cachexia Empyema</b><br>IMMEDIATE CAUSE (a)<br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bronchogenic Carcinoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of the soft palate</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                         |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>February 14</b> 19 <b>84</b> , to <b>February 22</b> 19 <b>84</b> , that (we) last saw the deceased alive on <b>February 22</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.   |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Bruce Shames</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2/23/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bruce Shames, M.D.</b>  |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  | 23b. DATE<br><b>2/27/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastveiw Mem. Pk.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                     |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H, Inc.</b>   |   | ADDRESS<br><b>1101 E North Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 24 1984</b> <i>Davidson-Randell</i> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FIBER

WATER

WATER

February 22, 1964

8:30P

Palatino City

Marvin General Hospital

Palatino

Bronchopneumonia and Cerebral

Bronchopneumonia Cerebral

Cerebral of the left palate

x

x

February 14 84 February 22 84

February 22 84

2/22/84

x

Marvin General Hospital

Marvin General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified by item 19.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 4 5 4 9

|   |  |   |   |  |                                   |
|---|--|---|---|--|-----------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Rosa</i>   |  | 2a. DATE OF DEATH<br><i>Feb 2 10 84</i>   |   | 2b. HOUR<br><i>M</i>   |                                   |
| 3. SEX<br><i>FEMALE</i>   | 4. RACE<br><i>BLACK</i>  | 5. DATE OF BIRTH<br>MONTH <i>10</i> DAY <i>12</i> YEAR <i>1907</i>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i> YRS  | 7. IF UNDER 1 YEAR<br>MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.        |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>VIRGINIA</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>US</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>CITY</i> MD.   |  |                                   |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>BON SECOURS HOSPITAL</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>RETIRED</i>              |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><i>MARYLAND</i>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><i>10 NORTH MONROE STREET 21223</i>          |                                   |
| 14. FATHER'S NAME<br>FIRST <i>WILLIAM</i> MIDDLE <i>FERGURSON</i> LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>MINNIE</i> MIDDLE LAST   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>  |  | 16b. SOCIAL SECURITY NO.  |   | 17. ADDRESS<br><i>RUSSELL MASON 10 NORTH MONROE ST. 21223</i>                  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |  |                                   |
| PART I. DEATH WAS CAUSED BY:  |  |   |   |  |                                   |
| IMMEDIATE CAUSE (a) <i>Stroke</i>   |  |   |   |  |                                   |
| 2859 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal Failure, CHF.</i>  |  |   |   |  |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Anemia</i>  |  |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |   |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |                                   |
| 22b. SIGNATURE<br><i>Forrest G. [Signature]</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><i>2/10/84</i>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>R. L. L. [Signature]</i>  |  | 22e. ADDRESS  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT) <i>BURIAL</i>  | 23b. DATE<br><i>2-14-84</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>KING MEM. PK.</i>  |   | 23d. LOCATION<br>CITY OR TOWN <i>BALTIMORE</i> COUNTY <i>MARYLAND</i> STATE    |                                   |
| 24. FUNERAL DIRECTOR<br>NAME <i>E.L. PHILLIPS</i> ADDRESS <i>1721 N. MONROE ST.</i>   |  | 25a. DATE REC'D. BY REGISTRAR <i>FEB 16 1984</i> 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |   |  |                                   |

BP

1000

1000

1000

1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |                  |   |  |   |  | REG. NO. 0 4 5 5 0  |  |
|--|-------------------------|---|--|---|------------------|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WAYNE LEON WALLACE</b>   |                         |   |  |   |                  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2-16-84</b> |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 25 1959</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN<br><b>24 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD<br><b>2-16-84</b>  |  | 24 HOUR<br>PM<br><b>10:00</b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lanscaper</b>                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ray George</b>                                |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET ADDRESS<br><b>2332 Barclay Street</b><br><b>Baltimore, Maryland 21218</b> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Roland Wallace</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Joan Taylor</b>   |                  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No.</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>217-66-8088</b>  |  | 17. INFORMANT<br><b>Mary Wallace</b>  |                  | ADDRESS<br><b>2332 Barclay St.</b><br><b>Baltimore, Maryland 21218</b>                                  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stabwound of chest</b><br><b>9660</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |   |  |   |                  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |   |                  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9PM 2-16-84</b>   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject stabbed</b> |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>  |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>400 Worsley St. Baltimore, Maryland</b>         |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>   |                         |   |  | TITLE (SPECIFY)<br><b>Assistant</b>   |                  |   |  | DATE SIGNED<br><b>2-17-84</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         |   |  | ADDRESS<br><b>111 Penn Street</b>   |                  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>2/22/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>  |                  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons Funeral Home Inc.</b><br><b>2501 Gwynn Falls Pkwy. Baltimore, Md. 21216</b>   |                         |   |  |   |                  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>                            |  |   |  |

MEDICAL CERTIFICATION

No. 11-8-0085  
 Baltimore, Maryland  
 John Taylor  
 3332 Barclay St.  
 Baltimore, Maryland 21218  
 U.S.A.

3301 Lynn Belle Ave. Baltimore, Md. 21218  
 Hunter & Hunt General Home Inc.  
 707/4627 W. 4th Street  
 Baltimore, Maryland

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | MONTHS DAYS HOURS MIN.  |  |
| EDWARD NORMAN WALTER  |  | 2 19 84  |  | 11:32 PM  |  |
| 1. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS (LAST BIRTHDAY))  | 7. UNDER 1 YEAR   |  |
| Male  | White  | MONTH DAY YEAR   | 62 YRS.  | 8. UNDER 24 HRS.  |  |
| Feb. 17, 1922   |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |
| Maryland  | U.S.A.   |  | BALTIMORE CITY MD.   |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| BALTIMORE   | Loch Raven Veterans Hospital   | Contractor   | Building   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE  |  |
| Md.   | Balto.   |  |  | Holly Lane 51212  |  |
| 14. FATHER'S NAME (TYPE OR PRINT)   | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)   | 16. ADDRESS  |  |   |  |
| Edward J. Walter  | Thelma R. Kurts  | Deerfield, Ill 60015   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  |  |   |  |
| Yes   | WW 11  | Edward N. Walter 65 Sequoia Lane   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   | 5 minute                                     |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Prostatic Carcinoma</u>  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |  |
|   |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from FEBRUARY 15, 1984, to FEBRUARY 19, 1984, that (X) (we) last saw the deceased alive on FEBRUARY 19, 1984, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| PAUL H. LEE MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 2/20/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |
| PAUL H. LEE MD  |  | Johns Hopkins Hospital - Dept. of Surgery  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 2-23-1984  |  | Meadowridge   |  |
| 24. FUNERAL DIRECTOR  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. DATE REC'D. BY REGISTRAR   |  |
| NAME Leonard J. Rucj, Inc. 5305 Harford Rd.   |  | DBRsey Md.   |  | FEB 22 1984   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

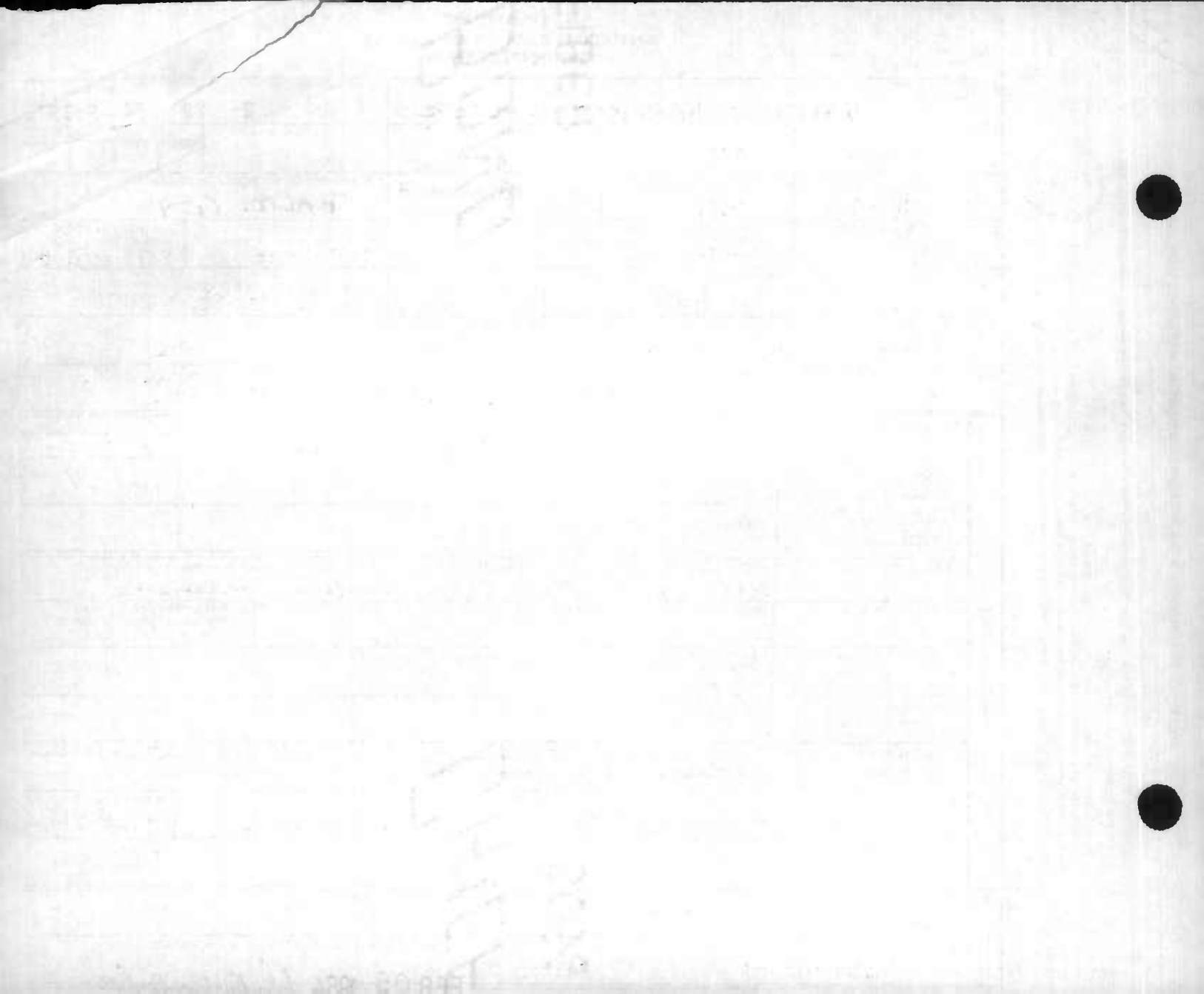
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND  |  |  |  |  |   |                                      |  |                        |  |  |
|--|--|--|--|--|---|--------------------------------------|--|------------------------|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   |                                      |  |                        |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |                                      |  |                        |  |  |
| REG. NO.   |  |  |  |  |   |                                      |  |                        |  |  |
| 1. FOR STATE REGISTRAR   |  |  |  |  | 2a. DATE OF DEATH   |                                      |  |                        |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2b. HOUR  |                                      |  |                        |  |  |
| FIRST MIDDLE LAST  |  |  |  |  | MONTH DAY YEAR  |                                      |  |                        |  |  |
| VALERIE HARRISSE WALTER  |  |  |  |  | 2 29 84 9:35 <sup>A</sup>   |                                      |  |                        |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | 7. UNDER 1 YEAR        |  |  |
| Female   |  | White  |  | MONTH DAY YEAR   |   | 92                                   |  | MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 10. UNDER 24 HRS.      |  |  |
| Maryland   |  | U.S.   |  |  |   | BALTO. CITY                          |  | MD.                    |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY    |  |                        |  |  |
| Balto.   |  | Keswick Home   |  | Sculptress   |   | Self employed                        |  |                        |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13d. INSIDE CITY LIMITS?  |                                      |  |                        |  |  |
| 13a. STATE   |  |  |  |  | 13e. STREET ADDRESS / ZIP CODE                                      |                                      |  |                        |  |  |
| Md.  |  |  |  |  | 202 E. 31st St. 21218   |                                      |  |                        |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |                                      |  |                        |  |  |
| FIRST MIDDLE LAST  |  |  |  |  | FIRST MIDDLE LAST   |                                      |  |                        |  |  |
| Moses R. Walter  |  |  |  |  | Bertha Ulman  |                                      |  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT ADDRESS  |                        |  |  |
| No   |  |  |  |  | 216-24-0042   |                                      | Ms. Sally Kirk 527 Walker Ave. Balto., Md.   |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |                                      |  |                        |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |                                      |  |                        |  |  |
| IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u>   |  |  |  |  |   |                                      |  |                        |  |  |
| 4850   |  |  |  |  |   |                                      |  |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |                                      |  |                        |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |   |                                      |  |                        |  |  |
| (b)  |  |  |  |  |   |                                      |  |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |                                      |  |                        |  |  |
| (c)  |  |  |  |  |   |                                      |  |                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |  |  |  |   |                                      |  |                        |  |  |
| <u>Arteriosclerotic cardiovascular disease</u>   |  |  |  |  |   |                                      |  |                        |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                      | 20a. AUTOPSY?  |                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |   |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY   |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                        |  |  |
|  |  |  |  |  | HOUR A.M. MONTH DAY YEAR  |                                      |  |                        |  |  |
|  |  |  |  |  | P.M. 19   |                                      |  |                        |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                      | 21f. LOCATION  |                        |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |   |                                      | STREET CITY OR TOWN COUNTY STATE   |                        |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>77</u> , to <u>29 Feb</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>29 Feb</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |                                      |  |                        |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                        | 22c. DATE SIGNED   |  |
| <u>Harold A. Brice MD</u>  |  |  |  |  |   |                                      |  |                        | <u>29 Feb 84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS  |                                      |  |                        |  |  |
|  |  |  |  |  |   |                                      |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY   |                        | 23d. LOCATION  |  |
| Removal  |  |  |  |  | 2/29/84   |                                      |  |                        | CITY OR TOWN COUNTY STATE                                      |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |                                      | 25b. REGISTRAR'S SIGNATURE   |                        |  |  |
| NAME   |  |  |  |  | ADDRESS   |                                      |  |                        |  |  |
| Anatomy Board  |  |  |  |  | Balto., Md.   |                                      |  |                        |  |  |

FEB 05 1984



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04553

1. FOR  
STATE  
REGISTRAR

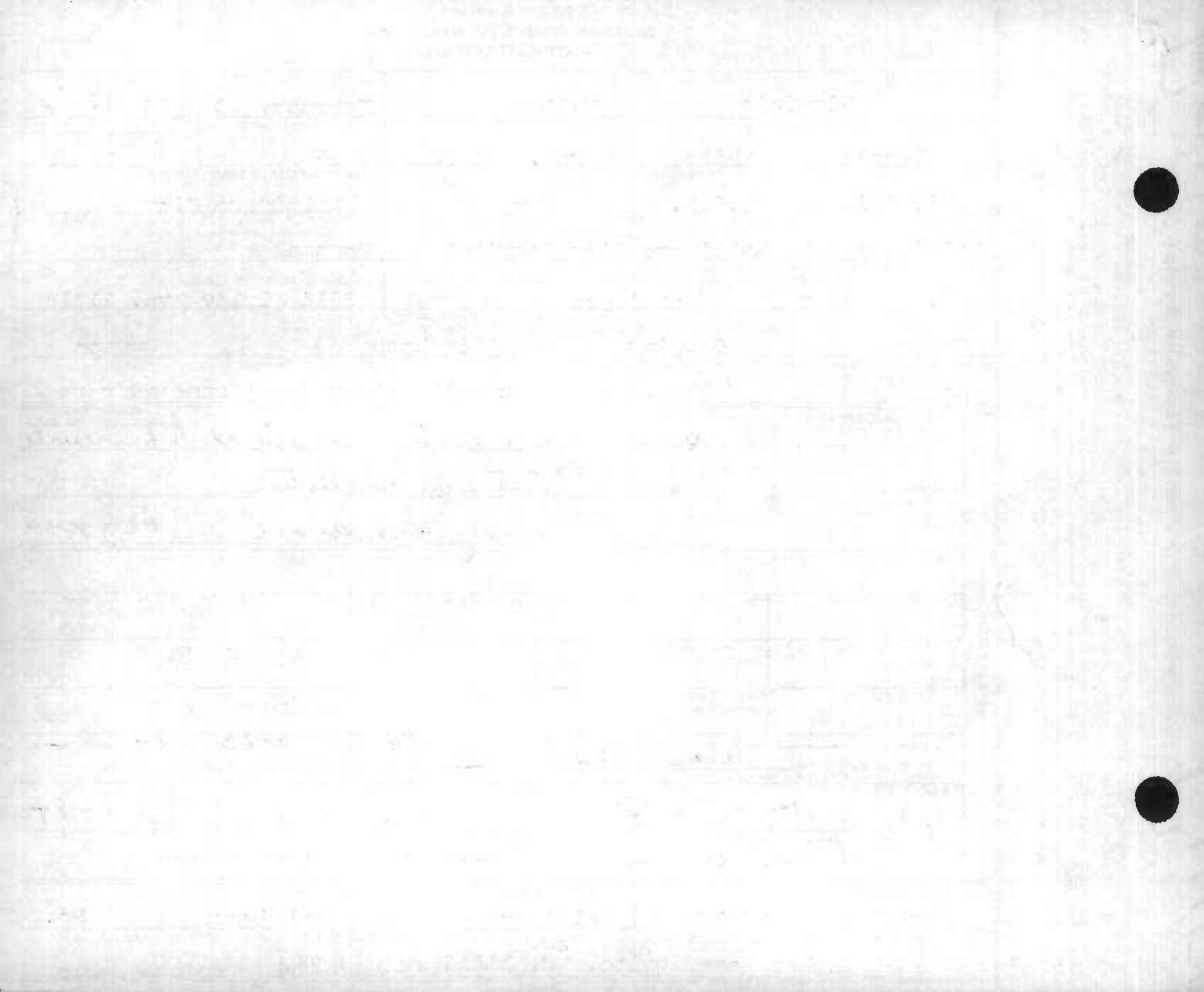
REG. NO.

|  |  |   |  |   |  |  |   |  |   |                                    |  |
|--|--|---|--|---|--|--|---|--|---|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Virginia Walter</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 23 1984</b>         |   |  | 2b. HOUR<br><b>2:00 P.M.</b>   |   |  |   |                                    |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 9 1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>87</b>                                 |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |   |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |   |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |   |                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3514 Elmley Ave. 21213</b> |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Gearing</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Dawson</b>  |  |  |   |  |   |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-74-2556</b>                         |   |  | 17. INFORMANT<br>ADDRESS<br><b>Russell Walter (son) same address</b>                 |   |  |   |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Cardiac Death, Cardiogenic Shock</b><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ventricular Fibrillation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Heart Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>"</b><br><b>many years</b> |  |   |  |   |  |  |   |  |   |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |  |   |  |   |                                    |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>P.M. 19</b>   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2-23 1984</b>    |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |   |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |                                    |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>2-1</b> 19 <b>84</b> , to <b>2-23</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-23</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |   |  |   |  |  |   |  |   |                                    |  |
| 22b. SIGNATURE<br><b>Dr. John Littleton</b> MD   |  |   |  |   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2-24-84</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. John Littleton</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>Eastpoint Medical Center</b>                                      |   |  |   |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>2/27/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |   |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schimunek Funeral Home, Inc.</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 28 1984</b>                                  |   |  |   |                                    |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Gelia Davidson</b>  |  |   |  |   |  |  |   |  |   |                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |  |  |   |   |   |  |  |
|---|--|--|---|---|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANK M. WALTERS (WOLTER)</b>  |  |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>19</b> YEAR <b>1984</b>     |   |  | 2b. HOUR <b>M</b>  |  |   |   |   |  |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>   |   | 5. DATE OF BIRTH MONTH <b>2</b> DAY <b>15</b> YEAR <b>1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>              |   | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD  |  |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO CITY HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BANK</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>BALTO</b>   |   | 13c. CITY OR TOWN <b>DUNDALK</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>8049 PARK HAVEN RD.</b>              |   |   |  |  |
| 14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>WALTER</b> LAST <b></b>   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE <b>URBANSKI</b> LAST <b></b>  |  |  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  |   | 16b. SOCIAL SECURITY NO. <b>213 098246</b>  |  | 17. INFORMANT ADDRESS <b>DOROTHY EBNER 8049 PARK HAVEN RD.</b>   |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |   |   |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>DIABETES MELLITUS, TYPE II</b>  |  |  |   |   |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 20</b> 19 <b>75</b> , to <b>FEB. 2</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>DEC. 14</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                       |  |  |   |   |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE <b>Teodulo J. Paglinawan</b> DEGREE  |  |  |   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED <b>2-21-84</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TEODULO J. PAGLINAWAN, MD</b>  |  |  |   |   |  | 22e. ADDRESS <b>7811 WISE AVE., BALTO. 21222</b>   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)   |  |  | 23b. DATE <b>2/23/1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b> |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b> |   |   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>RAYMOND H. KACZOROWSKI</b>   |  |  | 24b. ADDRESS <b>2525 FLEET ST</b>                                   |   |  | 25a. DATE RECD. BY REGISTRAR <b>FEB 24 1984</b>  |  |   | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04555

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |                     |
|---|--|---|--|--|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Eliza (JANIE) WARD |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 / 6 / 84 |  | 2b. HOUR<br>9:45 AM |
| 3. SEX<br>FEMALE  | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 / 29 / 96   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS                        |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wisconsin                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.       |                     |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                     |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |                     |

|   |                                |   |  |   |  |
|---|--------------------------------|---|--|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                     |                                |   | 13b. COUNTY  |   |  |
| 13a. STATE<br>Maryland  | 13c. CITY OR TOWN<br>Baltimore | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2950 Carver Road 21225              |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Theodore Sawyer   |                                |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNKNOWN |                                | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT ADDRESS<br>James O. Ward 2950 Carver Road |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 4860<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |
| (b) <u>PNEUMONIA</u>  |  |   |
| (c)   |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>1/11</u> , 19 <u>80</u> , to <u>2/6</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>2/6</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>L. CUETO</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/6/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEDUINA L. CUETO   |  |  |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL  |  |  |  |

|  |                      |   |  |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL | 23b. DATE<br>2/13/84 | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |
|--|----------------------|---|--|

|   |  |  |
|---|--|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H Inc. 1101 E North Avenue | 25a. DATE REC'D. BY REGISTRAR<br>FEB 14 1984 | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall |
|---|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIAN WARD</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 26, 1984</b>   |   | 2b. HOUR<br><b>9.32 PM</b>  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 28 1925</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Good Samaritan Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cook</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State College</b>      |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DARIUS WARD</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ora Lampkin</b>   |   | 13e. STREET ADDRESS<br><b>726 Mt. Holly Street Baltimore, Maryland 21229</b>                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>225-20-9145</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Oray I. Dixon Baltimore, Maryland 21229</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro VASCULAR accident.</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>obesity</b>   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/26</b> 19 <b>84</b> , to <b>2/26</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2/26</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                             |   |   |   |   |  |
| 22b. SIGNATURE<br><b>John Stinson</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>2/26/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN STINSON</b>   |   | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSP</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>3/3/1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Galilee United Methodist Church Cemetery</b>           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Northumberland Co. Virginia</b>   |   | 24. FUNERAL DIRECTOR<br>NAME<br><b>Nutter &amp; Sons Funeral Home Inc.</b><br><b>2501 Gwynns Falls Pkwy. Balto. Md. 21216</b>                               |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |   |   |  |

February 26, 1984

W. L. L. L.

58

7 48 1932

Female

Baltimore City

X

Virginia

Town

The Good Samaritan Hospital

Baltimore

Cook

State College

735 Mt. Holly Street

Baltimore, Maryland 21202

X

Baltimore

Maryland

1000 N. 10th

Ors

755 Mt. Holly Street

A Gray I. from Baltimore, Maryland 21202

Xc.

2501 Owens Falls Hwy. Baltimore, Md. 21216  
Nutter & Sons Funeral Home Inc.  
3/5/1984  
Gallie United Methodist  
1st Church Cemetery, Northampton Co. Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |                                       |  |   |   |  |
|---|--|--|---|---|---------------------------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ruby K. Ward</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>February 6 84</b>            |   |                                       | 2b. HOUR<br><b>6:35 PM</b>   |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 22 1906</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                      |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                                |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pvt. Families</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |  | 13b. COUNTY<br><b>Baltimore</b>                                     |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Caesar Keith</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hattie Rhue</b> |   |                                       | 13e. STREET ADDRESS / ZIP CODE<br><b>2822 Winchester St. Baltimore, Maryland 21216</b> |   |   |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b> |  | 16b. SOCIAL SECURITY NO.<br><b>215-16-6421</b> |  | 17. INFORMANT<br><b>Cleo Withthorn</b> |  | 17b. ADDRESS<br><b>115-32 158TH Street Queens, New York, 11432</b> |  |
|--|--|--|--|--|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4280</b> IMMEDIATE CAUSE (a) <b>Recurrent ventricular tachycardia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|---|--|---|--|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 6 1984</b> to <b>Feb 6 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 6 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>BUI</b>  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22c. DATE SIGNED<br><b>Feb 6/84</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CAN BUI</b>  |  |
| 22e. ADDRESS<br><b>2600 Liberty Street</b>  |  |  |  |

|  |  |                               |  |  |  |  |  |
|--|--|-------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                    |  | 23b. DATE<br><b>2/10/1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nutter &amp; Sons 2501 Gwynns Falls Pkwy.</b> |  |                               |  | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1984</b>                  |  |  |  |
| Funeral Home Inc. Baltimore, Maryland 21216                                      |  |                               |  | REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                     |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RALPH BABYLON WAREHIME Sr. XXXXXXXX   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 1, 1984  |  |   |  | 2b. HOUR<br>12:45A  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 10, 1900   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>83   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Police Lt.   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Overlea  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wesley Holloway Warehime   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Allison Babylon   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-03-0435   |  | 17. INFORMANT<br>ADDRESS 21206 Ave.<br>Jeannette E. Warehime, 5700 Kenwood  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |  |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a:<br>INTESTINAL OBSTRUCTION  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 31, 19 84, to FEBRUARY 2, 19 84, that (XX) lost saw the deceased alive and above, (X) (we) did not view the body after death, and that (my) (our) opinion death occurred on the date and hour and from the causes stated. |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>XXXXXX   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2-1-84  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BRUCE KINOSTAN  |  |  |  |   |  | 22e. ADDRESS<br>CHURCH HOSPITAL<br>100 NORTH BROADWAY 21231  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Feb. 4, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>XXX Overlea, Balto., Md.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Davis   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |  |
|---|---|---|--|
| 1- FOR STATE REGISTRAR <b>Leonard Washington</b> <b>CERTIFICATE OF DEATH</b> REG. NO. <b>04559</b>  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Wesley</b>   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 17 84</b>  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 18 1932</b>   |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W.Va.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b>  |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Retired</b>  |  |
| 13a. STATE<br><b>Md.</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   |  |
| 13c. CITY OR TOWN<br><b>Fimlico</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William T. Washington</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Myrtle V. Allen</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>233-48-6473</b>  |  |
| 17. INFORMANT ADDRESS<br><b>Virginia James Kearneysville, W.Va.</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5789</b><br>IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>C.2 block</b>                            |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cervical Anoxia</b>   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |  |
| 22b. SIGNATURE<br><b>Brian Zickerman</b>  |   | 22c. DATE SIGNED<br><b>2/17/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Brian Zickerman</b>   |   | 22e. ADDRESS<br><b>Baltimore City Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Feb. 22, 1984</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Pauls Cemetery</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Kearneysville Jeff. W.Va.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Douglas R. Snowden</b>  |   | 25. REGISTERED BY REGISTRAR<br><b>Charles Town, W.Va.</b>   |  |
| 26. REGISTRAR'S SIGNATURE<br><b>FEB 27 1984</b>   |   | 27. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |



|           |                         |         |
|-----------|-------------------------|---------|
| Black     | 1934                    | 21      |
| W.Va.     | U.S.                    | X       |
| Baltimore | Baltimore City Hospital | retired |
| W.D.      | Baltimore City          | Unknown |
| W.D.      | T.                      | W.D.    |
| W.D.      | W.D.                    | W.D.    |

Feb. 25, 1934, St. Pauls Cemetery, Kernersville, N.C.

Feb. 27, 1934, St. Pauls Cemetery, Kernersville, N.C.



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |  |  |   | REG. NO.                                       |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LORRAINE E. WASHINGTON  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 17 84 |   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 5 32   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1817 W. MULBERRY STREET |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1817 W. Mulberry St. 21223  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George H. Washington  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Carter   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>216-28-3304   |  | 17. INFORMANT<br>ADDRESS<br>Frank D. Washington 4846 Claybury Ave  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                         |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/83</u> 19 <u>82</u> , to <u>11/17/83</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/17/83</u> 19 <u>83</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>(I/we) did/did not</u> view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Sheldon H. Gottlieb M.D.</u>   |  |  |  | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>2/20/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sheldon H. GOTTIEB, M.D.   |  |  |  | 22e. ADDRESS<br>BALTIMORE CITY HOSP. Bldg. 21224  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>2/22/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Md.                                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H Inc. 1101 E North Avenue   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Rendall</u>                                      |  |  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

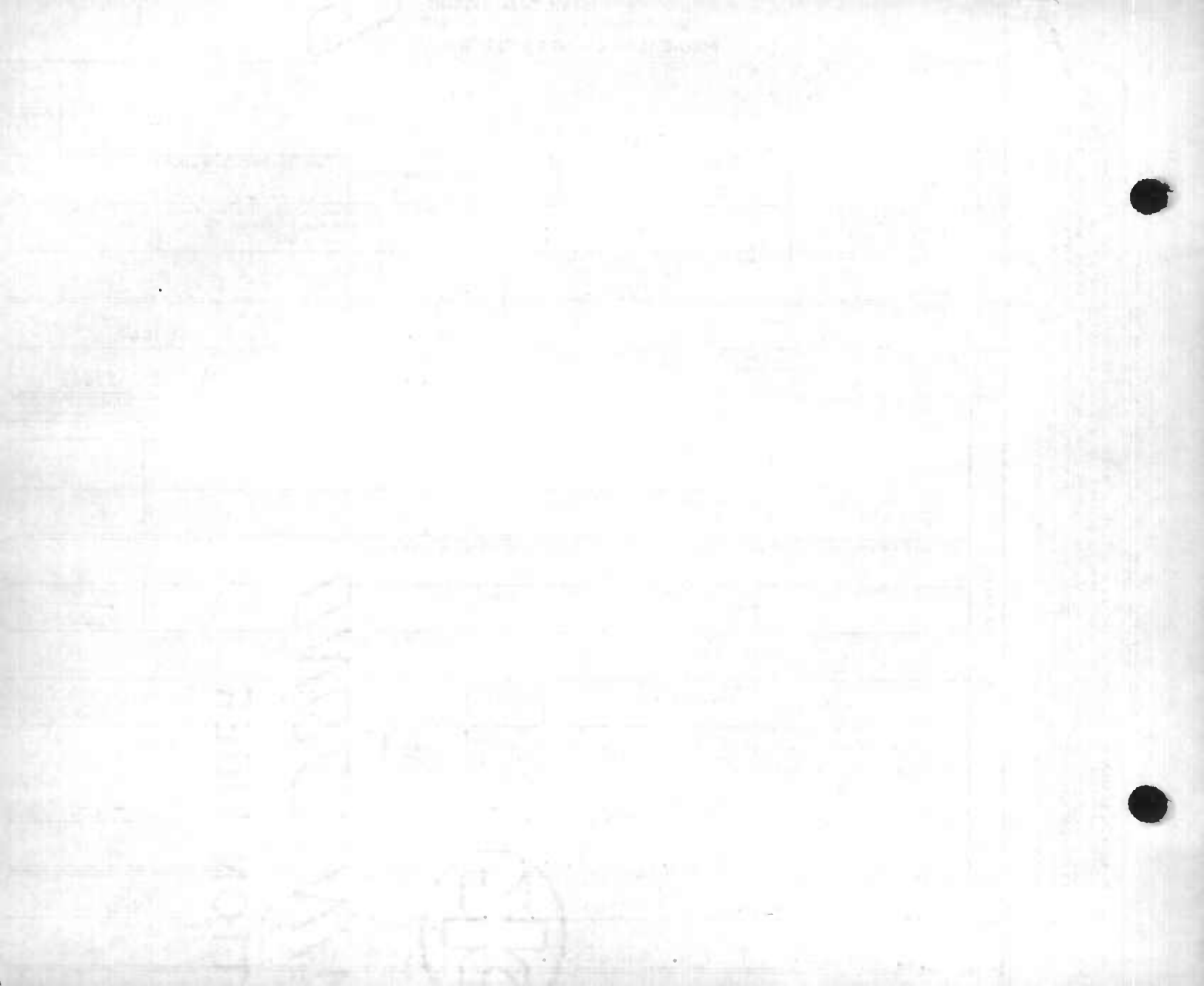
DHMH - 17  
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20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
|--|---------|--|--|---|--|---|--|--------------------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| STAFFORD   |         |  |  |   |  | WASHINGTON  |  | 2-10-84                              |  | 19                       |  |       |  |      |  | M        |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| MALE   | BLACK   | 9 30 1940  |  | 42 YRS.   |  |   |  |                                      |  | 2-10-84                  |  | 19    |  |      |  | M        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |  |       |  |      |  | MD.      |  |
| MARYLAND   |         | US   |  |   |  |   |  | Baltimore City                       |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Baltimore  |         | Johns Hopkins Hospital   |  | DISABLED  |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                          |  |       |  |      |  |          |  |
| MARYLAND   |         |  |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4007 HAYWOOD AVE. 21215              |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| ERIC   |         | LOUISE WALLS   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                      |  |                          |  |       |  |      |  |          |  |
|  |         |  |  | ERIC WASHINGTON   |  | 4007 HAYWARD 21215  |  |                                      |  |                          |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hanging</u><br><u>9530</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____ |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
|  |         |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
|  |         | 2-10-84  |  | subject hanged self   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
|  |         | jail cell  |  | Baltimore City Jail, Baltimore, Maryland  |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
|  |         |  |  | 401 E. Eager Street   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:  |         | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | DATE SIGNED   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Margarita A. Korell  |         | M.D. ASSISTANT MEDICAL EXAMINER  |  | 2-10-84   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Margarita A. Korell, M.D.  |         | 111 Penn Street  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (CITY OR TOWN)  |  | COUNTY                               |  | STATE                    |  |       |  |      |  |          |  |
| BURIAL   |         | 2-19-83  |  | KING MEM. PK.   |  | BALTIMORE   |  | MARYLAND                             |  |                          |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                      |  |                          |  |       |  |      |  |          |  |
| E.L. PHILLIPS  |         | 1721 N. MONROE ST.   |  | FEB 16 1984   |  | E. L. Phillips  |  |                                      |  |                          |  |       |  |      |  |          |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04562

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret Y. Wathen                               |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 28 84 |   |  | 2b. HOUR<br>1045 AM   |  |
| 3. SEX<br>female  |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 22 01  |  | 6. AGE [IN YEARS LAST BIRTHDAY]<br>82 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |   |   |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>St. Mary's  |   | 13c. CITY OR TOWN<br>Leonardtown  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert N. Yates                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary R. Abell   |   | 13e. STREET ADDRESS / ZIP CODE<br>General Delivery 20650  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-42-1625   |   | 17. INFORMANT<br>Address<br>Inpatient Registration Record   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiopulmonary arrest  
6869  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) brain death

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

10 minutes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

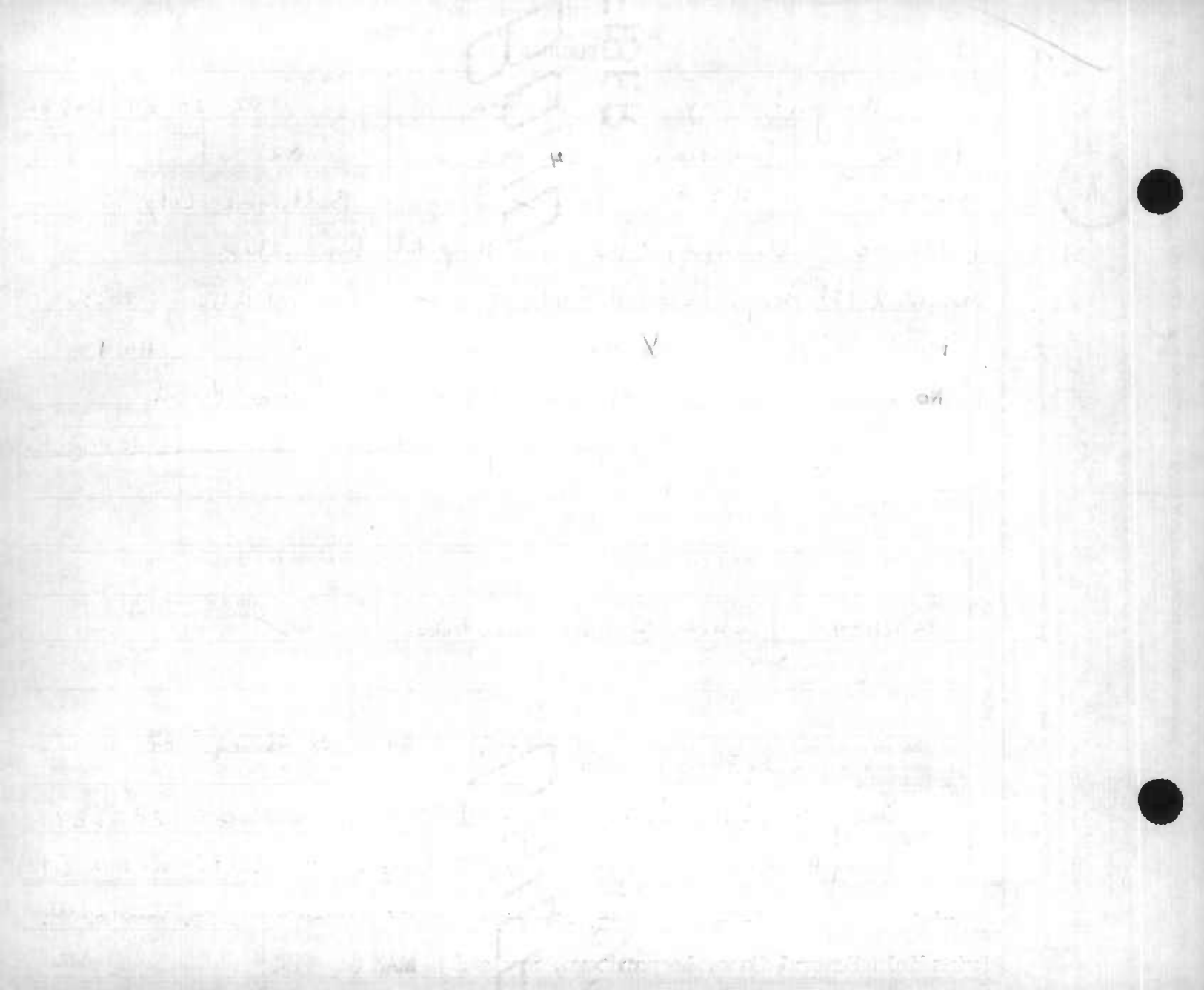
|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br>20 Feb 84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>infected @ thigh hematoma |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 February</u> 19 <u>84</u> , to <u>28 February</u> 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>28 February</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Barry H. Wells M.D.   |  |   |  | DEGREE   |  | 22c. DATE SIGNED<br>28 Feb 84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barry H. Wells   |  |   |  | 22e. ADDRESS<br>22 S. Greene St. Baltimore MD 21201                                  |  |   |  |

|  |  |                     |  |  |  |  |  |
|--|--|---------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                         |  | 23b. DATE<br>3-3-84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Aloysius Catholic Leonardtown, St. Mary's, Md. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Leonardtown, St. Mary's, Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brinsfield Funeral Home, Leonardtown, Maryland |  |                     |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAR 6 1984 Davidson-Randall  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CCU/7

04 89 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and that it be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |  |  |   |   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALBERT WATKINS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 20, 1984</b>        |   |   | 2b. HOUR<br><b>11:32 M</b>   |   |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 28 21</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                    |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Watkins</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosetta Marrow</b> |   |   | 13e. STREET ADDRESS<br><b>21202 501 E. Preston St. Apt 604</b>                       |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-10-6425</b>                         |   | 17. INFORMANT ADDRESS<br><b>Mattie Watson 1319 Gorsuch Avenue</b>               |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Dilated cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial infarction</b> |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12h</b><br><b>1y</b><br><b>1y</b>                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Sepsis, pneumonia, renal failure, hepatic failure</b>   |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/19</b> , 19 <b>84</b> , to <b>2/20</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/20</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>George Brittan</b>   |  |  |  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>2/20/84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George Brittan</b>  |  |  |  |   | 22e. ADDRESS<br><b>To Johns Hopkins Hospital</b>                                |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>2/23/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA Owings Mills,</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc, 1101 E North Ave.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1984</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>                                      |  |  |

BP

25 P. 2 1100

2000 COLUMBIA

CHILLY





TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 16b G589 Film

FOR  
1 - STATE  
REGISTRAR  
3/1/84 jpSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 4 5 6 4

REG. NO.

|  |  |   |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>/FIRST MIDDLE LAST<br><b>ROBERT LEE WATKINS</b><br><b>2 (WARREN)</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 25, 1984</b>   |  |   |  | 2b. HOUR<br><b>10:13AM</b>  |  |  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 17 37</b>  |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>46</b>   |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b>                  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS<br><b>624 E 37th Street 21218</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Watkins</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kate Lawson</b>   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-325-5232</b>       |  |
| 17. INFORMANT<br><b>Marion R. Watkins</b>  |  |   |  | 17. ADDRESS<br><b>624 East 37th St.</b>   |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4275 IMMEDIATE CAUSE (a) Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 minutes</b> |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 25, 19 84</b> , to <b>Feb 25, 19 84</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Essie J. Woods</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>2/25/84</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Essie J. Woods</b>   |  |   |  | 22e. ADDRESS  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  |   |  | 23b. DATE<br><b>3/2/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 28 1984</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julian Davidson</b>  |  |  |  |   |  |

POST OFFICE

CHIEF INM



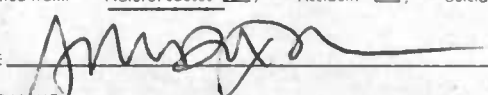

The page contains several lines of extremely faint, illegible text, likely bleed-through from the reverse side of the document. Some fragments are visible, such as 'PAGE 1' at the top left and 'CHIEF INM' on the right side, which also appears as a large vertical stamp.

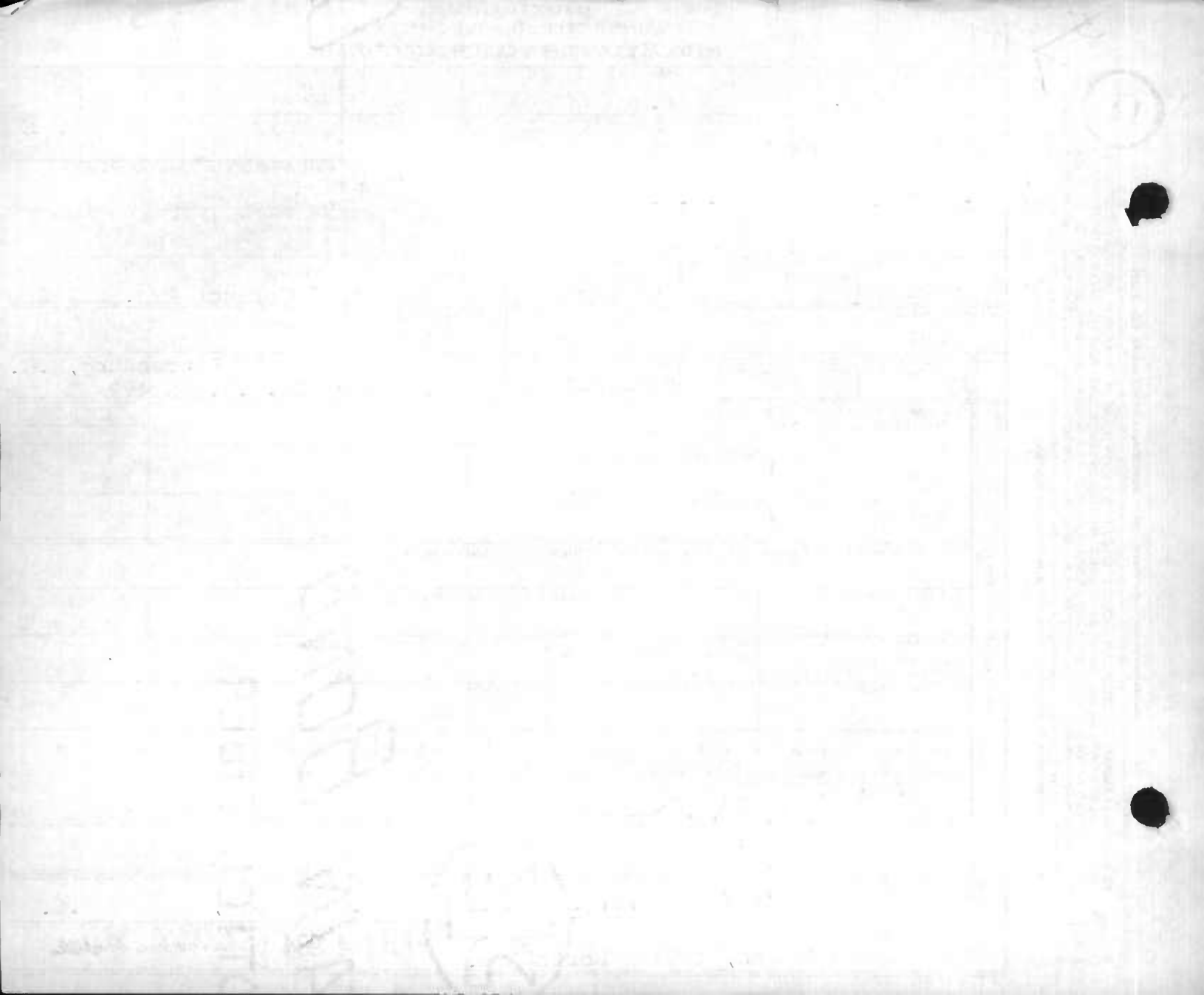
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |                  |   |  |   |  | REG. NO. |  |
|--|-------------------------|--|--|---|------------------|---|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>FLORENCE H. WATSON</b>   |                         |  |  |   |                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2 9 1984</b>          |  | 2b. HOUR<br>M<br><b>7:59 a</b>                        |  |          |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 1 20</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>64</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2 9 1984</b>   |  | 2d. HOUR<br>M<br><b>7:59 a</b>                        |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1646 Gorsuch Ave.</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |          |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>1646 Gorsuch Ave. 21218</b> |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Nelson</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sallie</b>  |                  |   |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>247-20-7543</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Laurenborg, N.C.</b>   |                  | 17. INFORMANT<br>ADDRESS<br><b>Moses Watson Jr. P.O. Box 492</b>  |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                         |  |  |   |                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |  |  |   |                  |   |  |   |  |          |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |   |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                  |   |  |   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                  |   |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |  |   |                  |   |  |   |  |          |  |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |                  | DATE SIGNED <b>2-9-84</b>   |  |   |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |                         | ADDRESS <b>111 Penn St., Balto., MD. 21201</b>   |  |   |                  |   |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>2/14/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillside Memorial Pl</b>   |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurenborg, N.C.</b>   |  |   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc,</b>   |                         | ADDRESS<br><b>1101 E North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1984</b>   |                  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |          |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |                              |  |   |  |  |
|---|--|---|---|---|------------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Cynthia Lynn WATTS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 21 84                   |   |                              | 2b. HOUR<br>2:04PM<br>M  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 21 1983   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>6 6   |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   |   |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dependent  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Dundalk |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bobby Joe Rasnake   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eleanor A. Watts |   |                              | 16. STREET ADDRESS<br>8000 Kavanagh Road 21222   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>216-04-8838   |   | 17. INFORMANT<br>ADDRESS<br>Eleanor A. Watts  |                              | Same as 13e  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>7480<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEPSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CHRONIC INTESTINAL INJURY</u> |  |   |   |   |                              |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 minutes   |  |
|   |  |   |   |   |                              |  |   | 3 months   |  |
|   |  |   |   |   |                              |  |   | 6 months   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>MAL NUTRITION</u>   |  |   |   |   |                              |  |   |  |  |
| 19a. DATE OF OPERATION<br>10/10/83  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CHOANAL ATRESIA   |   |   |                              | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> N.A.<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. N.A. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>N.A.  |                              |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> N.A. <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>N.A.  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>N.A.   |                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 21</u> , 19 <u>83</u> , to <u>February 21</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>February 21</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |   |   |   |                              |  |   |  |  |
| 22b. SIGNATURE<br>Linda M. Famiglio, M.D.   |  |   |   |   |                              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>Feb 21, 1984   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LINDA M. FAMIGLIO, M.D.  |  |   |   |   |                              | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2/24/1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>ADDRESS 7922 Wise Avenue Dundalk, MD. 21222   |  |   |   |   |                              | 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1984   |   | 25b. REGISTRAR'S SIGNATURE   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO  
LIBRARY  
CHICAGO, ILL. 60637  
1957



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04567

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |   |   |  |   |                                   |  |
|---|--|---|--|---|---|---|---|--|---|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JEROME WATTS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>6</b> YEAR <b>84</b>                          |   |   | 2b. HOUR<br><b>9:30</b> P M   |   |  |   |                                   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>8</b> YEAR <b>1925</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.   |   |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city MD.</b>                     |   |  |   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>cab driver</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                                   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>21223 2918 Edmondson Ave.</b> |                                   |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Harrell</b> LAST <b>Harrell</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Hazel</b> MIDDLE <b>Harrell</b> LAST <b>Harrell</b> |   |   |   |   |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>unknown</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-23-684</b>   |  | 17. INFORMANT<br><b>Eleanor Watts</b>   |   | ADDRESS<br><b>2918 Edmondson Ave</b>  |   |  |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cachexia</b><br><b>1509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cancer of oesophagus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |  |   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH         |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |   |  |   |   |   |   |  |   |                                   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                        |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |   |  |   |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/6</b> 19 <b>84</b> , to <b>2/6</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/6</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |   |  |   |                                   |  |
| 22b. SIGNATURE<br><b>Bui T Duong</b>  |  |   |  |   |   | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/6/84</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BICH T DUONG</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>  |   |  |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>2-7-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Louisa Park Cem. Co. Baltimore</b> |   |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>  |   |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Brown-Thompson F.H.</b> ADDRESS <b>1913 W. Baltimore St.</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1984</b>                                    |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gail</b>  |   |                                   |  |

MEDICAL CERTIFICATION





STATE OF MARYLAND

0 4 5 6 8

1- FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

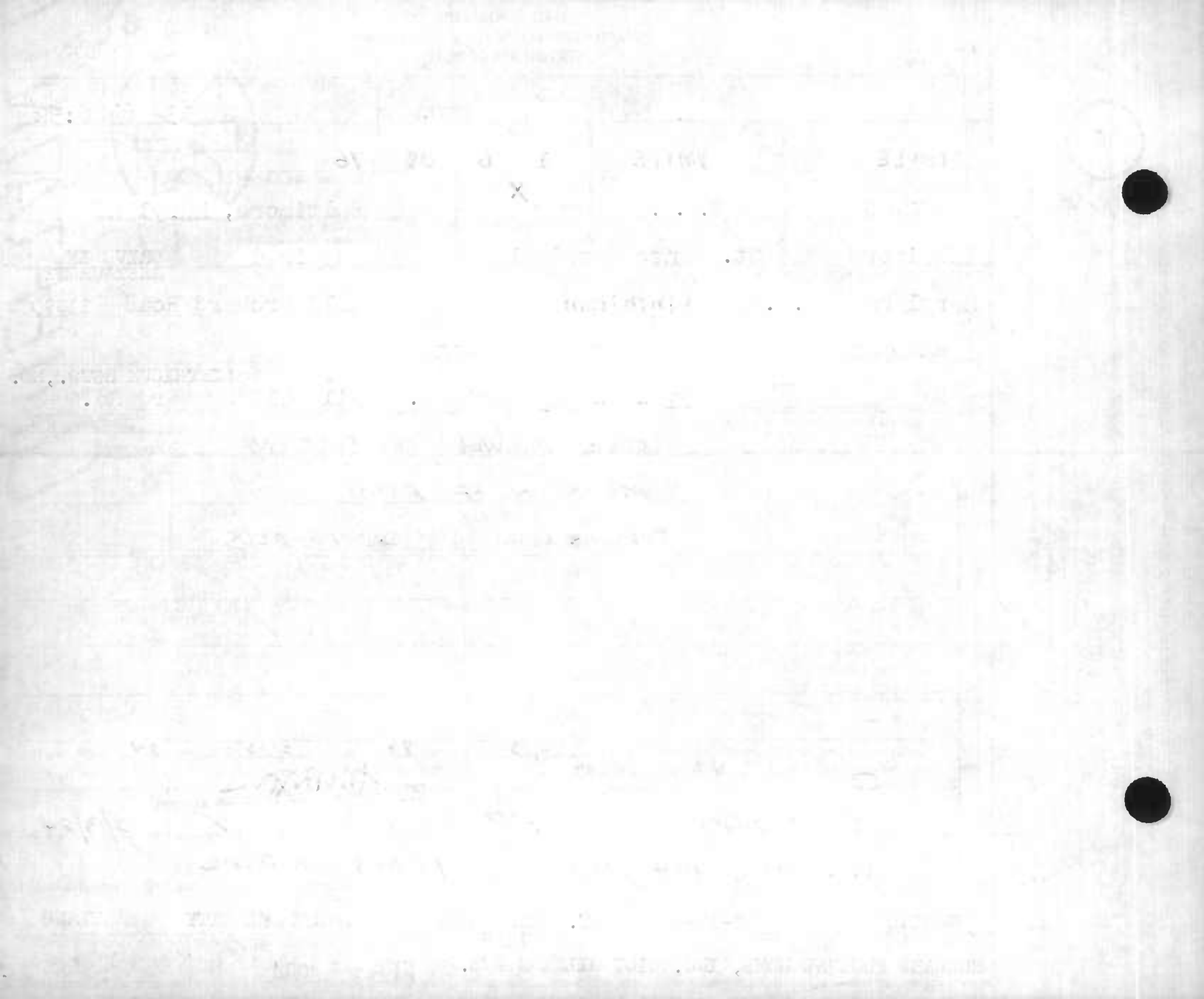
REG. NO.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ANNA M. WEAVER (MUSIL)  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 13 84                               |  | 2b. HOUR<br>6:58 PM  |
| 3 SEX<br>FEMALE  | 4 RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 6 08   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OWNER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>DRIVE IN RESTAURANT   |
| 13a. STATE<br>Maryland   |   |  | 13b. COUNTY<br>A.A.CO   | 13c. CITY OR TOWN<br>Linthicum Heights   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MAXMILLIAN BARANOWSKI  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>AMELIA  |   | 13e. STREET ADDRESS<br>6412 Orchard Road 21090                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-22-8303   |   | 17. INFORMANT<br>ADDRESS<br>Doris A. Musil 6412 Orchard Rd.                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) LOWER AIRWAY OBSTRUCTION<br>3320<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASPIRATION OF FOOD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) PARKINSONISM ; HYDROCEPHALUS |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13 19 84 to 2/13 19 84, that (I) (we) last saw the deceased alive on 2/13 19 84, and that in (my) (our) opinion date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |   |  |  |
| 22b. SIGNATURE<br>William L yap  |   | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>2/13/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM L. YAP MD   |   | 22e. ADDRESS<br>ST. AGNES HOSPITAL   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |   | 23b. DATE<br>02-17-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. STANISLAUS                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND  |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 15 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>Selia Davidson-Randall                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04569

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |  |   |  |  |
|---|--|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Albert Weinberg</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02/21/84</b>                                  |   |   | 2b. HOUR<br><b>3:36P<sub>M</sub></b>   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 18, 1914</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AGENT</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>INSURANCE</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>3512 LANGREHR RD. APT. 1-A (21207)</b>   |  |  |   |   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISAAC WEINBERG</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LENA HURWITZ</b>                    |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-8802</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>APT. 1-A<br/>MRS. MOLLYE WEINBERG 3512 LANGREHR RD., 21207</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAL ARREST</b><br><b>4241</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MYOASTHINOSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>16 min</b><br><b>4-7 days</b> |  |  |   |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>2/10/84</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>AORTIC REGURGITATION; C.A.D.</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2/10 1984</b>                     |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/21 1984</b> to <b>2/21 1984</b> , that (I) (we) last saw the deceased alive on <b>2/21 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Charles D. Cousar</b>  |  |  | DEGREE<br><b>M.D.</b>   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/21/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C.D. COUSAR</b>   |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>2/22/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOSES MONTEFIORE CEM</b>                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BRUS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>  |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

242832

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR<br><b>GRACE T. WELLMAN</b>  |  | REG. NO.<br><b>04570</b>  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>GRACE T. WELLMAN</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2/9/84</b>  |  | 2b. HOUR<br><b>5:25 PM</b>  |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1/23/03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SOCIAL SECURITY</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MARYLAND</b>  |  |   |  | 13c. CITY OR TOWN<br><b>LINTHICUM</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>615 FAIRMONT RD. 21090</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE HARMAN RINEHART</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZA ROBY</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>235-05-4834</b>   |  | 17. INFORMANT ADDRESS<br><b>HARMON M. TABOR 5904 BALTIMORE AVE. 21207</b>                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1830 IMMEDIATE CAUSE (a) MULTIPLE PULMONARY EMBOLI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ADENOCARCINOMA (? OVARY OR LUNG)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>HOURS</b><br><b>MONTHS</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>MARKED ATHEROSCLEROSIS</b>   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>James S Taylor</b>  |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>2/10/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES E. TAYLOR, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/13/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE CEMETERY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>DORSEY MARYLAND</b>                            |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>LEROY &amp; RUSSELL WITZKE FUNERAL HOMES P.A.</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1984</b>   |  |   |  |
| 1630 EDMONDSON AVENUE BALTIMORE MD. 21228  |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Gina Davidson-Hendell</b>                                      |  |   |  |



2/24/51  
 T. J. Williams  
 1911  
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U.S. ...  
 T. J. Williams  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B that any injury or other traumatic event has medical significance, it must be certified on page 4.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 04571   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George Herbert Wells</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2-4-84</b>   |  |   |  |
| 3. SEX <b>Male</b>  |  |   |  | 2b. HOUR <b>12:50 P.M.</b>   |  |   |  |
| 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>4-29-14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.   |  | IF UNDER 74 HRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALD, USA MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO City</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>So. Baltimore Gen. Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>City</b>   |  |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>✓</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME <b>Raymond</b>  |  | 15. MOTHER'S MAIDEN NAME <b>Catherine</b>   |  | 13e. STREET ADDRESS ZIP CODE <b>1308 Hester Ave. 21230</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO. <b>217-097716</b>  |  | 17. INFORMANT ADDRESS <b>Mr. Richard Anderson Above</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Heart failure sec. to myocardial Infarction</b><br>(c) <b>Chronic Heart failure</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Obstructive Pulmonary Disease</b>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-4</b> 19 <b>84</b> , to <b>2-4</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-4</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Martin Guerrero MD</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>2-4-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Martin Guerrero</b>  |  | 22e. ADDRESS <b>3001 So. Hanover St. Balti. MD</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>cremation</b>  |  | 23b. DATE <b>2/6/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore MD</b>   |  |
| 24. FUNERAL DIRECTOR <b>John J. Comanor Inc.</b>  |  | ADDRESS <b>2001 So. Hanover St.</b>   |  | DATE REC'D BY REG. <b>FEB 7 1984</b>   |  | REGISTRAR'S SIGNATURE <b>John J. Comanor</b>  |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   |  | REG. NO.  |   |
|--|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES JOSEPH WELSH SR.  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 11, 1984                    |  | 2b. HOUR<br>12:30 a.m.  |   |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 18, 1914  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5130 Hillburn Ave. (Residence) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Seafood  |   |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Welsh   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ellen Catherine McGarry    |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>212-03-0739   |   | 17. INFORMANT<br>Germantown Maryland<br>Dr. James J. Welsh Jr. 14621 Seneca Road   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>uræmia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>bladder cancer &amp; hepatic metastases</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cause of enteric infection</u> |   |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on <u>2/11/84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   |   |
| 22b. SIGNATURE<br>Dr. James J. Welsh Jr. M.D.  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>11 Feb 84   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Entombment   |   | 23b. DATE<br>Feb 14 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 14 1984   |   |   |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 04573  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Z L (WELCHEL)  |  |   |  |
| 3. SEX M  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 02 04 84   |  |   |  |
| 4. RACE B   |  |   |  | 2b. HOUR 520 A.M.   |  |   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 07 04 17  |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA   |  |   |  | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |   |  |
| 7b. CITIZEN OF WHAT COUNTRY? USA  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE MARYLAND 13b. COUNTY USA 13c. CITY OR TOWN BALTIMORE   |  |   |  | 13d. INSIDE CITY LIMITS? YES NO   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Whelchel   |  |   |  | 13e. STREET ADDRESS 1220 N. Dukeland St 21016   |  |   |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Earmon Jackson   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  |   |  |
| 16b. SOCIAL SECURITY NO. 252-28-9170  |  |   |  | 17. INFORMANT ADDRESS Elizabeth Whelchel 1220 N. Dukeland St  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Adrenal Insufficiency<br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) Large cell lung CA c. adn. metastasis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES NO  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                    |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/26/84 to 2/4/84, that (I/we) last saw the deceased alive on 2/4/84, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (If (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE MEENAKSHI Merchants MD   |  |   |  | 22c. DATE SIGNED 2/4/84   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEENAKSHI   |  |   |  | 22e. ADDRESS SINAI HOSP, BALTO.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 2/8/84  |  | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.                  |  |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue   |  |   |  | 25a. DATE REC'D. BY REGISTRAR FEB 6 1984  |  |   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE John J. Smith  |  |   |  |

2010-10-10-1010

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| FOR<br>1 - STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOSEPH VOSS WHITE  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 26, 1984  |  |
| 3. SEX<br>Male   |  | 2b. HOUR a<br>11:59 M  |  |
| 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 4, 1900  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Center |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Office Mgr.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Casting-Foundry Co.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD  |  | 13b. COUNTY Balto.   |  |
| 13c. CITY OR TOWN Cockeysville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 13e. STREET ADDRESS / ZIP CODE<br>1345 Falls Rd. 21030   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Horace Waters White   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ellin North Elder  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>217 12 9440  |  |
| 17. INFORMANT ADDRESS<br>Davison D. White, Balto., MD 21217  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 min<br>20 yrs |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Chronic Renal Failure / COPD</u>  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 8, 1983</u> to <u>2/26, 1984</u> , that (I) (we) last saw the deceased alive on <u>Jan 1984</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |
| 22b. SIGNATURE<br><u>Warren Ross M.D.</u>  |  | 22c. DATE SIGNED<br>2/27/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Warren Ross, M.D.   |  | 22e. ADDRESS<br>3900 N. Charles St., Balto., MD  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>2/27/84   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., MD  |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.   |  | 25. DATE REC'D. BY REGISTRAR<br>FEB 27 1984  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>4905 York Road Balto., MD 21212  |  | 25. REGISTRAR'S SIGNATURE<br><u>Davidson-Randell</u>   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

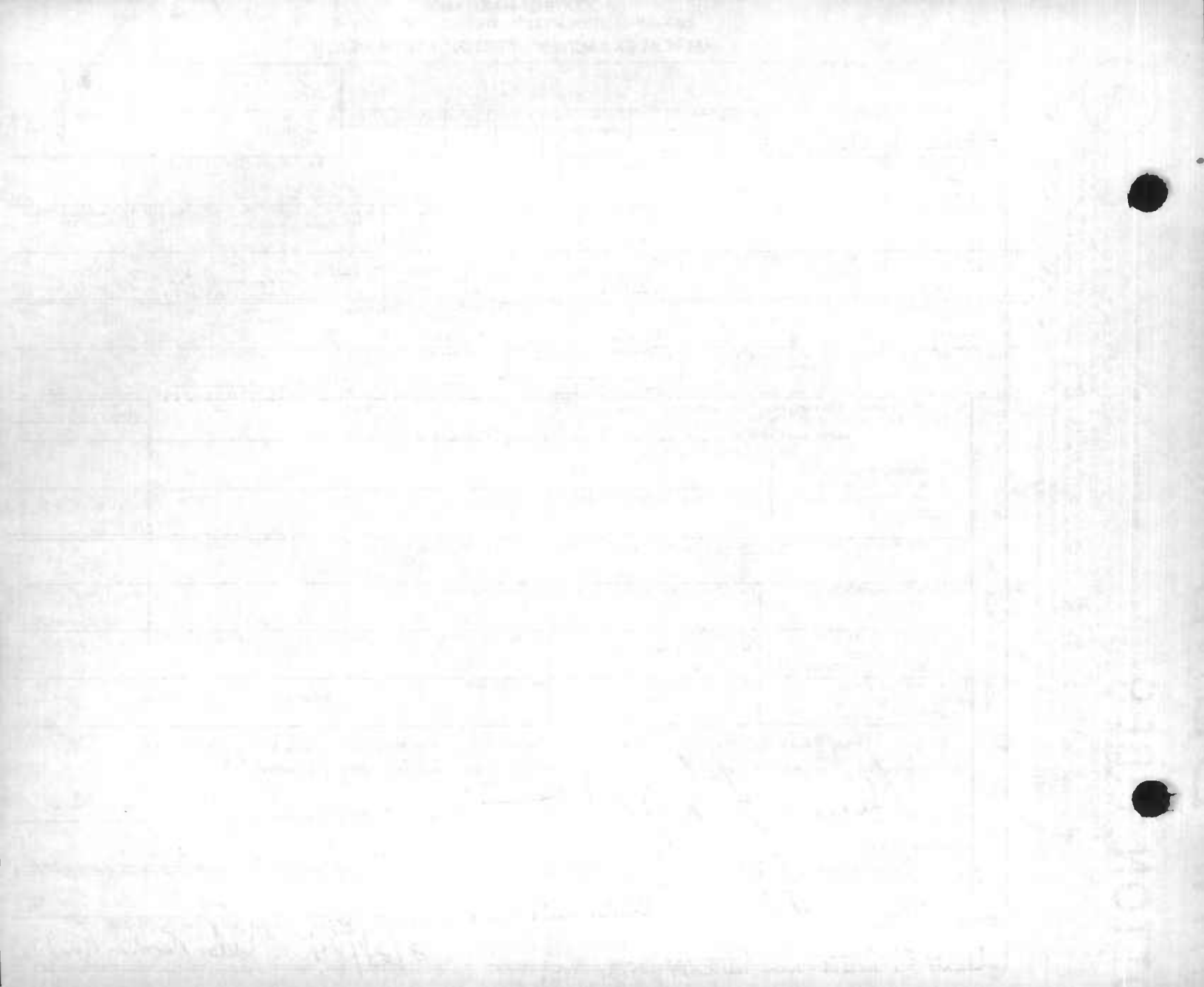
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |                  |                |  |  |                                      |  |   |               |                                   |  |   |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
|---|--|------------------|----------------|--|--|--------------------------------------|--|---|---------------|-----------------------------------|--|---|--|--|------------|---|--|-----------|--|--|--------------|--|--|----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  | FIRST<br>Marie |  |  | MIDDLE<br>F                          |  |   | LAST<br>White |                                   |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED   |  |  | MONTH<br>2 |   |  | DAY<br>27 |  |  | YEAR<br>1984 |  |  | 2b. HOUR<br>M<br>10:05<br>P<br>M |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>BLACK |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 26 11   |  | 6. AGE (IN YEARS<br>(BIRTHDAY)<br>72 |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS  |               | 8. IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE<br>PRONOUNCED<br>DEAD  |  |  | MONTH<br>2 |   |  | DAY<br>27 |  |  | YEAR<br>1984 |  |  | 2d. HOUR<br>M<br>10:05<br>P<br>M |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>NORTH CAR.  |  |                  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |               |                                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3105 Brighton Street |  |                                      |  |   |               |                                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |  |  |            | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |           |  |  |              |  |  |                                  |  |  |
| 13a. STATE<br>MD.   |  |                  |                | 13b. COUNTY  |  |                                      |  | 13c. CITY OR TOWN<br>BALTO.   |               |                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |            | 13e. STREET ADDRESS<br>3105 BRIGHTON ST. 21216                                      |  |           |  |  |              |  |  |                                  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>AUSTIN JONES  |  |                  |                |  |  |                                      |  |   |               |                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JULIA  |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |                  |                | 16b. SOCIAL SECURITY NO.<br>216-09-3792A   |  |                                      |  | 17. INFORMANT<br>DAISY HORNE 3105 BRIGHTON ST.  |               |                                   |  |   |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                  |                |  |  |                                      |  |   |               |                                   |  |   |  |  |            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |  |           |  |  |              |  |  |                                  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |                |  |  |                                      |  |   |               |                                   |  |   |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| 19a. DATE OF OPERATION  |  |                  |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                      |  |   |               |                                   |  |   |  |  |            | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |           |  |  |              |  |  |                                  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |               |                                   |  |   |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |                | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |               |                                   |  |   |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |                |  |  |                                      |  |   |               |                                   |  |   |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| ACTUAL<br>SIGNATURE<br>Dennis F. Smyth M.D.   |  |                  |                | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |                                      |  | DATE<br>SIGNED 2/28/84  |               |                                   |  |   |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  |                  |                | ADDRESS<br>111 Penn St. Balto., MD.  |  |                                      |  |   |               |                                   |  |   |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |                  |                | 23b. DATE<br>3/2/84  |  |                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTO. NAT. CEM.  |               |                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |  |  |            |   |  |           |  |  |              |  |  |                                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LEROY O. DYETT  |  |                  |                | ADDRESS<br>4600 LIBERTY HGTS. AVE.   |  |                                      |  | 25a. DATE RECEIVED BY REGISTRAR<br>2/28/84  |               |                                   |  |   |  |  |            | REGISTRAR'S SIGNATURE<br>Davidson-Randall   |  |           |  |  |              |  |  |                                  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

A

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |   |   |  |
|---|--|--|--|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM W WHITE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>13</b> YEAR <b>84</b>       |   |  | 2b. HOUR<br><b>M</b>   |  |   |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>1929</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lincoln Comm. Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>md</b> 13a. COUNTY <b>AA</b> 13a. CITY OR TOWN <b>Glenn Burnie</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>7345 Furman Branch Rd</b>  |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>White</b> LAST <b>White</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Evelyn</b> MIDDLE <b>Green</b> LAST <b>Green</b>  |  |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES) <b>-</b> |  |   |   |  |
| 16a. SOCIAL SECURITY NO.<br><b>220-22-5597</b>  |  | 17. INFORMANT<br><b>Evelyn Wms</b>   |  |   |  | 17. ADDRESS<br><b>Balt. Md 21210</b>   |  |   |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br><b>1629</b><br>IMMEDIATE CAUSE (a): <b>Carcinoma of lung with</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b): <b>Metastasis, terminal</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c): <b>Malnutrition</b>   |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>10</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                 |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> 19 <b>83</b> to <b>2-13</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-13</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death. |  |  |  |   |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>A. I. Baykaler MD</b>  |  |  | 22c. ADDRESS<br><b>831 Poplar Grove St. Bal.</b>                       |   |  | 22d. DATE SIGNED<br><b>2-13-84</b>   |  | 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. I. BAYKALER, MD.</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2-17-84</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Zion</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pasadena AA md</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Samuel B. Oden - Balto. Md.</b> ADDRESS <b>Balto. Md.</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1984</b>                    |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Guth Davidson-Randell</b>   |  |   |   |  |

BP

W. J. ...  
A. A. ...  
William ...  
No ...

W. J. ...  
A. A. ...  
William ...  
No ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>William Henry Whitehurst Sr.</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>2-14-84</i>                  |   |  | 2b. HOUR<br><i>9 A.</i> M.   |   |  |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10-29-1912</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>71</i> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto. Md.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Church Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Shipping Dept.</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>H.S. Crocher</i>   |  |
| 13a. STATE<br><i>Md.</i>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><i>Balto.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William Whitehurst</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Matilda Bevig</i>  |   |  | 13e. STREET ADDRESS / ZIP CODE<br><i>2537 Fait Avenue - 21224</i>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |   | 16b. SOCIAL SECURITY NO.<br><i>232-26-1248</i>                         |   | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Marie K. Whitehurst - 2537 Fait Ave. 21224</i> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Atherosclerotic Vascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |   |  |  |
| 22a. I certify that (I) (this <del>person</del> <i>OFFICE</i> ) attended the deceased from <i>6/17</i> 19 <i>83</i> , to <i>present</i> 19 <i>84</i> , that (I) (we) lost <i>OFFICE</i> saw the deceased alive on <i>6/17</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Robert Liberto, MD</i>  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>2-15-84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ROBERT LIBERTO</i>   |  |   | 22e. ADDRESS<br><i>2938 St Paul St 21218</i>                           |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>2-17-84</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Cemetery</i>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md. - 21213</i>                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i>  |  |   |  |   |  |  |   |  |  |

FEB 16 1984

158 DATE REC'D. BY REGISTRAR 256 REGISTRAR'S SIGNATURE  
*Lia Davidson-Randall*



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |   |  |  |  |
|---|--|---|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VIOLA W. WHITTAKER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 12, 1984</b>                                     |   |  | 2b. HOUR<br><b>9:30 PM</b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 10 1933</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>IF UNDER 24 HRS.</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corporation</b> |   |   |  | 12. MAIN OCCUPATION<br>(TYPE WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>                                      |   | 13. FIRM, BUSINESS OR INDUSTRY<br><b>Ft. Howard VAMC</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3486 Loganview Dr. 21222</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gilbert</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maude Dellinger</b>                             |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>        |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-30-9899</b>  |  |   | 17. INFORMANT<br>ADDRESS <b>3486 Loganview Dr.</b><br><b>Richard K. Whittaker-Balto., MD. 21222</b> |   |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>METASTASIS ADENOCARCINOMA OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                              |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB. 12</b> <b>84</b> <b>FEB. 6</b> <b>84</b> to <b>FEB. 12</b> <b>84</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Y.K. SHETTY</b>  |  |   | DEGREE<br><b>MD</b>   |   |  | ATTENDING MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN |   | 22c. DATE SIGNED<br><b>2/12/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Y.K. SHETTY</b>   |  |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION</b><br><b>100 N. BROADWAY, BALTIMORE, MD. 21231</b>  |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>2/16/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn</b>                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Marriottsville Maryland</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>  |  |   | ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 15 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |

BP

VIOLA WHITTAKER

100

100

100

100



VIOLA WHITTAKER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

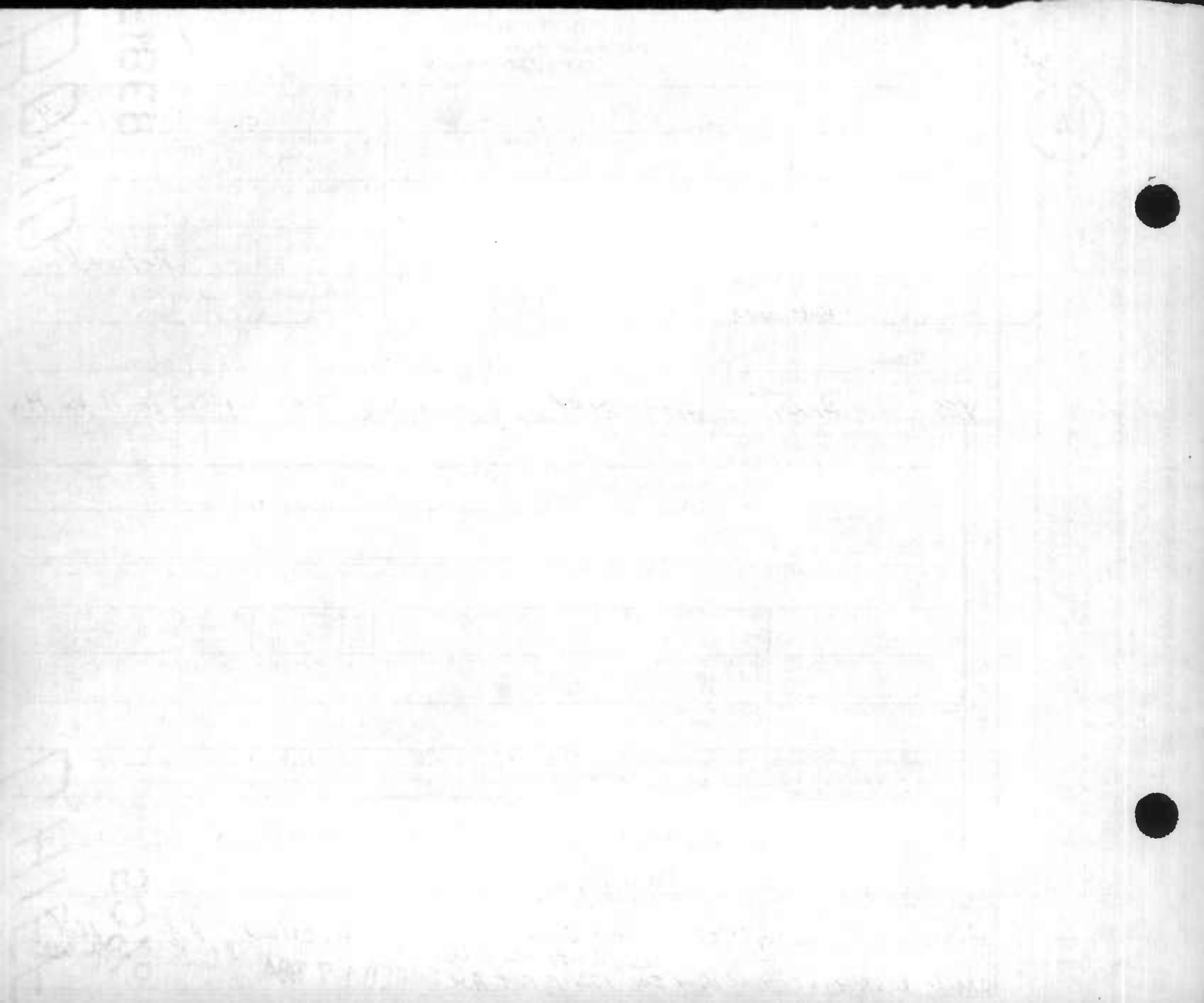
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 04579  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Walter Alexander Whitty</u>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <u>02-15-84</u>  |  |   |  |
| 3. SEX <u>MALE</u>   |  |   |  | 2b. HOUR <u>12:04 PM</u>  |  |   |  |
| 4. RACE <u>WHITE</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <u>Feb 7 1917</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Connecticut</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General Hosp</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <u>LABORER</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>  |  |
| 13a. STATE <u>Maryland</u>   |  | 13b. CITY OR TOWN <u>Baltimore</u>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS / ZIP CODE <u>1442 Cooks Rd St 21230</u>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <u>James Whitty</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <u>Mary McDougall</u>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>YES</u>   |  |   |  |
| 16b. SOCIAL SECURITY NO. <u>214-14-2458</u>  |  | 17. INFORMANT <u>Olga Melendez</u>  |  | ADDRESS <u>3001 S. Hanover St. Ba Ho</u>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio pulmonary insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic obstructive pulmonary disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>4960   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 13</u> , 19 <u>84</u> , to <u>Feb 16</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>Feb 15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>HAROLD BLUMENFELDER / Olga Melendez</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>Feb 16, 1984</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HAROLD BLUMENFELDER / Olga Melendez</u>   |  |   |  | 22e. ADDRESS <u>3001 S. Hanover St.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>BURIAL</u>   |  | 23b. DATE <u>2/18/84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEM.</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <u>BROOKLYN A.D. Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>CHARLES L. STEVENS FUNERAL HOME INC.</u>   |  | ADDRESS <u>1501 12 FORT AVE</u>   |  | 25a. DATE REC'D. BY REGISTRAR <u>FEB 17 1984</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>   |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  | REG. NO.   |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARET E WIDERMANN</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/3/1984</b> |  | 2b. HOUR<br><b>7<sup>40</sup> AM</b>         |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/10/1916</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Saint Agnes Hospital</b>                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary-Interpreter</b> |  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Balto. City</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robin Milburn Widerman</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katie May Hidey</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215-03-3985</b>  |  | 17. INFORMANT<br><b>Mr. Edwin Widerman</b>   |  |
|   |   | 3022 Rolling Road Baltimore, Maryland 21207   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic ovarian carcinoma</b><br><b>1830</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/31</b> , 19 <b>84</b> , to <b>2/3</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Qui Dien Huynh</b>   |   |   |  | 22c. DATE SIGNED<br><b>2-3-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>QUI DIEN HUYNH</b>  |   |   |  | 22e. ADDRESS<br><b>ST AGNES HOSPITAL CATON AV - BALTO - MD 21229</b>                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>2-6-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olive Cemetery Randallstown, MD.</b>              |  |
| 23d. LOCATION<br><b>Balto. City</b>   |   | 24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Road Randallstown, MD. 21133</b>  |  |  |  |
| 25a. DATE RECEIVED BY REG. CLERK<br><b>FEB 3 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be retained by the funeral director. The funeral director should be notified of the death as soon as possible.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

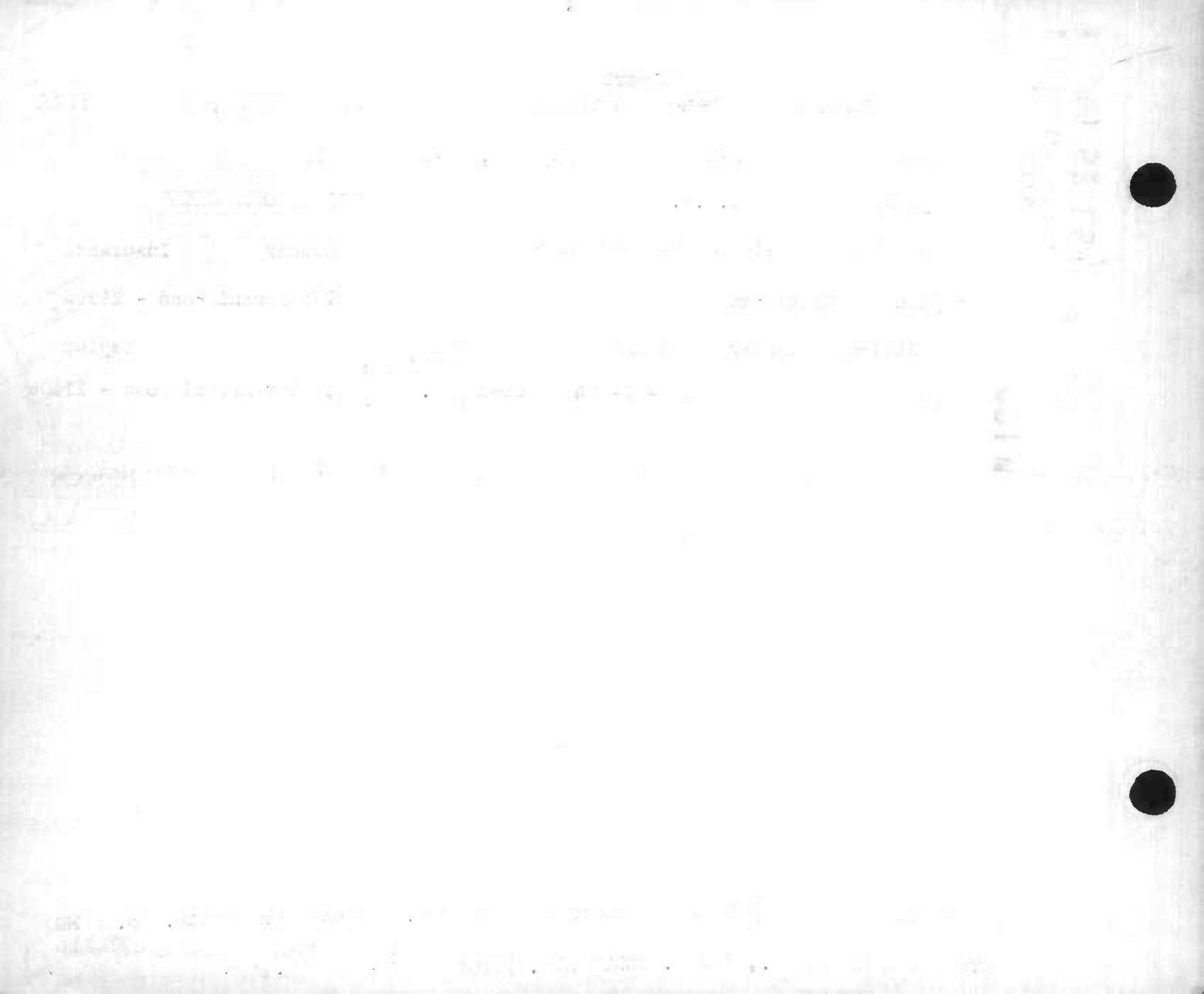
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM - G. WIDMAN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 22, 1984</b>        |   |  | 2b. HOUR<br><b>5:32A</b>   |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 19, 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Broker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Conrad Widman</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Taylor</b>   |   |  | 16. STREET ADDRESS / ZIP CODE<br><b>4709 Mawani Road - 21206</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-8840</b>   |  | 17. INFORMANT <b>Widow:</b> ADDRESS<br><b>Dorothy B. Widman, 4709 Mawani Road - 21206</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>pneumonia</b> |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min</b><br><b>15 hrs</b><br><b>6 wks</b>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/4</b> 19 <b>84</b> to <b>2/22</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/22</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Dallabetta</b>  |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/22/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dallabetta</b>   |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                          |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2/25/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto. Co. MD</b>                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>STEWART &amp; MOWEN CO., 108 W. NORTH AVE. 21201</b>  |  |  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 27 1984</b> <b>John Davidson-Randall</b>                              |   |  |  |

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IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04582

|  |   |   |  |
|--|---|---|--|
| 1. FOR STATE REGISTRAR   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ANTHONY WIDZIEWICZ  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 2 84<br>2b. HOUR<br>M                       |  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 22 29  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>54  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenance      |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1829 Aliceanna St.                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hotel  |  |
| 13a. STATE<br>Md.  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Widziewicz   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Josephine Rodziewicz  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   | 16b. SOCIAL SECURITY NO.<br>203-22-9670   | 17. INFORMANT ADDRESS<br>Mrs. Jean Blateck 173 Coketown Rd. Coraopolis, Pa. 15108 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br>Chronic Obstructive Lung Disease, Emphysema   |   |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |   |   |  |
| 22b. SIGNATURE<br>[Signature]<br>22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GRACIA V. PATRICIA   |   | 22d. DATE SIGNED  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |   | 23b. DATE<br>2/1/84   | 23c. NAME OF CEMETERY OR CREMATORY   |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 10 1984                                      |  |
| ADDRESS<br>Balto., Md.   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

CHIEF 14W

20% COTTON FIB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>VERNON ALBERT WIEBER   |  |  |  | 2b. HOUR<br>9:10 P.M.   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 14 18  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen. Hosp. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Md. Dry Dock  |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Lansdowne   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph A. Wieber  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Florence Steinwell  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME (UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WW II   |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-05-3002   |  |  |  |
| 17. INFORMANT ADDRESS<br>Elizabeth Wieber 3223 Ryerson Circle 21227  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal lymphocytic Leukemia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute pulmonary edema</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Spleno-hepato-megaly</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCD</u> |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> , 19 <u>84</u> , to <u>2/17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>James T. Heiser M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>2/17/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James T. Heiser M.D.  |  |  |  | 22e. ADDRESS<br>3001 S. Hanover Baltimore, MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/21/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Felia Davidson   |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04584

REG. NO.

|  |  |   |  |   |  |   |   |  |  |  |
|--|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES WILKINS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-11-84                         |   |  | 2b. HOUR<br>11:15 AM  |   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 3 06   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Phoebus, VA.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.                                    |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bethlehem STEEL |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>STEEL   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>1a. STATE<br>Md.   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2200 Bryant Ave. 21217 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Wilkins  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Wilkins  |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Grace Dawkins 5022 Belle Ave.                      |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>1850 DUE TO, OR AS A CONSEQUENCE OF<br>(b) prostate carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 minutes<br>since 1976   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |   |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19/83, 19____, to 2/10/84, 19____, that (I) (we) lost<br>saw the deceased alive on 2/10/84, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                              |  |   |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Dorothy Snow   |  |   |  |   | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DOROTHY ANN SNOW  |  |   |  |   | 22e. ADDRESS<br>3900 Loch Raven Blvd BALT.   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>2-11-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTO. NATIONAL  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JAS. A. MORTON & SONS  |  |   |  |   | ADDRESS<br>1701 LAURENS  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 15 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell     |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04585

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BELLE J. WILLIAMS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>17</b> YEAR <b>84</b>       |   |  | 2b. HOUR <b>1:30</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>2</b> YEAR <b>99</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 7a. BIRTHPLACE<br>(COUNTRY) <b>N. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>city</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BAIT</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MASON F LORD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>MD</b>   |  | 13b. COUNTY<br><b>BAIT</b>   |  | 13c. CITY OR TOWN<br><b>BAIT</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4320 Clareway</b> Apt. 4-T 21213  |  |
| 14. FATHER'S NAME<br>FIRST <b>Jenkins</b> MIDDLE <b>J</b> LAST <b>Jenkins</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Land</b> MIDDLE <b>L</b> LAST <b>Land</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>424 01 8920</b>   |  | 17. INFORMANT<br><b>Pauline Winchester</b>  |  |   |  | ADDRESS<br><b>7901 Gough St. 21224</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>resp arrest</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-<br><b></b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b></b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>            |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> 19 <b>84</b> to <b>2/17</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/17</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>(S) Contoreggi MD</b>  |  |  |  |   |  | 22c. DATE SIGNED<br><b>2/17/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>(S) Contoreggi</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>MASON F LORD</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>   |  | 23b. DATE<br><b>2/18/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Balto. Md.</b>                                |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Duda-Ruck Inc. 7922 Wise Ave. 21222</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>E. Anderson-Randell</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 4 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

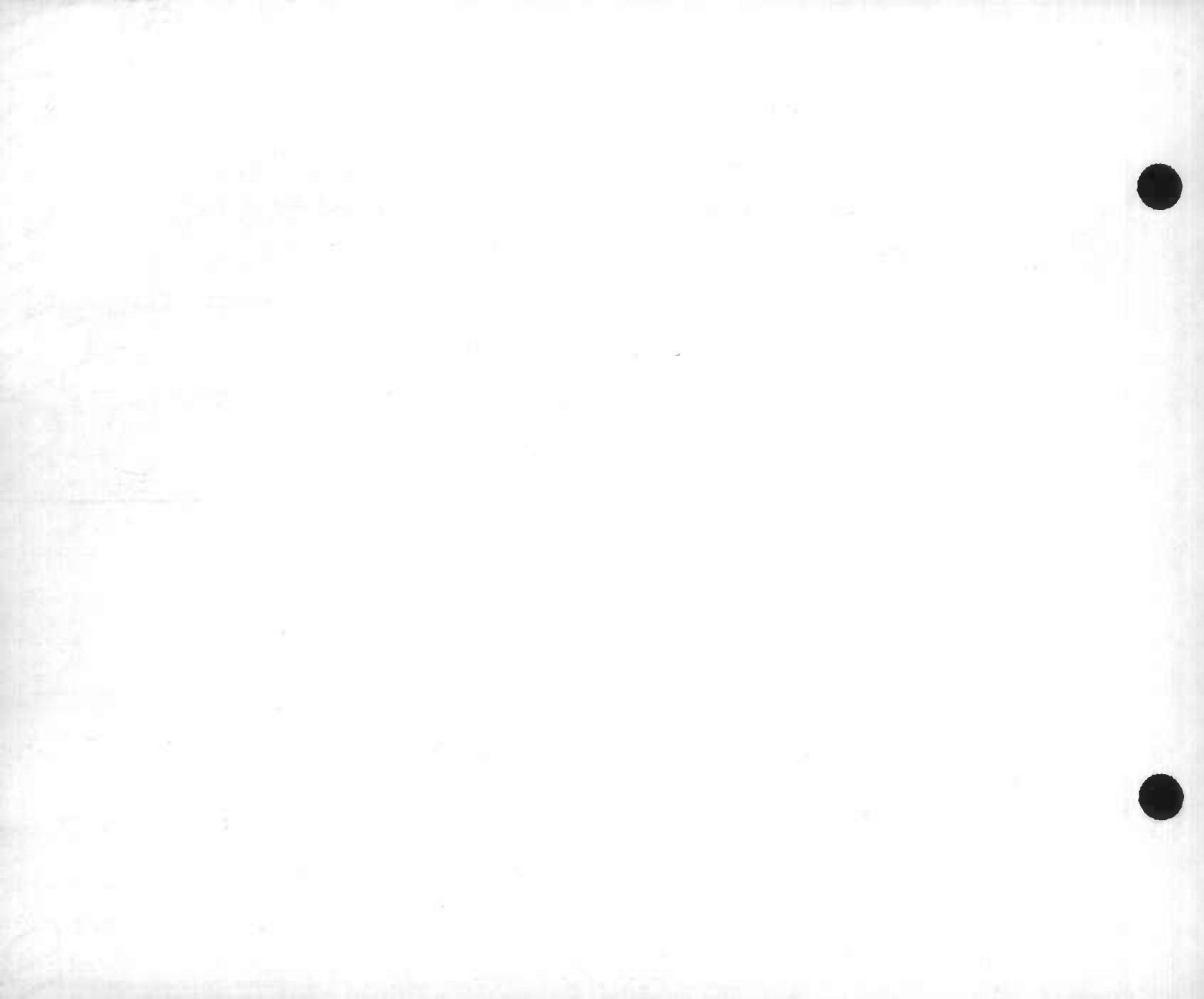
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|--|--|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ben L. Williams   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 22 84 |  | 2b. HOUR<br>10 <sup>05</sup> P.M. |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 28 1904                                      |                                   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.   |                                   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self Employed    |                                   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Service Station   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland               |   | 13b. COUNTY<br>Baltimore   |                                   |  |
| 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |   | 13e. STREET ADDRESS / ZIP CODE<br>1122 S. Bonsal St. 21224                           |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James L. Williams  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Daisey Harland  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-03-0365   |   | 17. INFORMANT<br>ADDRESS<br>Bonnie P. Williams Same as 13e                           |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Probable sepsis<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CVA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5d |  |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17, 1984, to 2/22, 1984, that (I) (we) lost saw the deceased alive on 2/22, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |  |                                   |  |
| 22b. SIGNATURE<br>MICHAEL S. DONNENBERG  |  | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>2/22/84  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL S. DONNENBERG   |  | 22e. ADDRESS<br>BALTO CITY HOSP  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/25/1984   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn                                       |                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |  |   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1984   |                                   |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |  |

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                      |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |
|---|--|----------------------|--|---|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CORDELL P. WILLIAMS JR.</b>  |  |                      |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>2 29 19 84</b> |  | 2b. HOUR <b>10:25 PM</b>  |  |  |  |  |  |  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3 24 66</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>17 YRS.</b>                        |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD <b>2 29 19 84</b>  |  | 7d. HOUR <b>10:25 PM</b>  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>  |  | MD   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>640 Hillview Rd.</b> |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |  |  |  |  |
| 13a. STATE <b>Maryland</b>  |  |                      |  | 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |  |  | 13e. STREET ADDRESS <b>640 Hillview Road 21225</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Cordell P. Williams</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Jacqueline Moody</b> |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>  |  |                      |  |   |  | 16b. SOCIAL SECURITY NO.  |  |  |  |   |  | 17. INFORMANT ADDRESS <b>Lelia Harrison 640 Hillview Road</b>                                     |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9551</b> IMMEDIATE CAUSE (a) <b>Shotgun wound of head</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                      |  |   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                      |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  | 20. AUTOPSY? <b>Head Only</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR <b>10:20 PM</b> MONTH DAY YEAR <b>2-29- 19 84</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted.</b>   |  |   |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>  |  |   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>640 Hillview Rd., Balto. Md.</b>  |  |   |  |   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .                         |  |                      |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b>  |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>  |  |   |  | DATE SIGNED <b>3-1-84</b>  |  |   |  | M.D. <b>Ann M. Dixon, M.D.</b>  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |                      |  | ADDRESS <b>111 Penn st., Balto., Md. 21201</b>  |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |  |                      |  | 23b. DATE <b>3/3/84</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Dobson's Family Cem</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Glenburnie</b>                                      |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |                      |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1984</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>   |  |   |  |   |  |  |  |  |  |  |  |

CONFIDENTIAL

UNITED STATES GOVERNMENT

CONFIDENTIAL

CONFIDENTIAL



CONFIDENTIAL

Page 423

S. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked either 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |                                   | REG. NO.                                       |  |
|---|--|---|--|--|--|---|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH WILLIAMS</b>   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>18</b> YEAR <b>84</b> |   |  | 2b. HOUR <b>11:30</b> PM  |                                   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>4</b> YEAR <b>93</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |                                   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                              |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |   |  |   |                                   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1301 Crofton Road 21239</b>  |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b></b> LAST <b>Bolden</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nannie</b> MIDDLE <b></b> LAST <b>Brown</b>   |  |   |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-52-0760</b>  |  | 17. INFORMANT ADDRESS<br><b>Nannie A. Jackson 1301 Crofton Road</b>  |  |   |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Poor left ventricular function</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |  |  |  |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Abundant fibrillation with rapid ventricular rate, old myocardial infarction</b>  |  |   |  |  |  |   |  |   |                                   |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/11</b> , 19 <b>84</b> , to <b>2/18</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |                                   |  |  |
| 22b. SIGNATURE<br><b>Benjamin Bieber</b>  |  |   |  | DEGREE <b>Resident</b><br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>2/18/84</b>  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Benjamin Bieber, MD</b>   |  |   |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>   |  |   |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2/24/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Monroe Bapt. Ch. Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Rice,</b> COUNTY <b>Virginia</b> STATE <b></b>                 |  |   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H Inc, 1101 E North Avenue</b> ADDRESS <b></b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. H. Davidson</b>   |                                   |  |  |

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CHARTER

RECEIVED

CHARTER

CHARTER

CHARTER

\* ...  
X

10/10/10

10/10/10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items #5 3/5/84 mtb F#509

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04589

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES WILLIAMS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 10, 1984</b>                         |   | 2b. HOUR<br><b>9:10P.M.</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 31 1923</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME &amp; HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>POSTAL CLERK</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CLEMENT WILLIAMS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE JOHNSON</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br><b>FERDA WILLIAMS 2301 DUKELAND ST. 21216</b>                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 years</b> |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>HYPERTENSION</b><br><b>Hypertension</b>  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) <u>this hospital</u> attended the deceased from <b>FEBRUARY 10, 1984</b> , to <b>FEBRUARY 10, 1984</b> , that (1) <u>we</u> last saw the deceased alive on <b>FEBRUARY 10, 1984</b> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> (did) <u>did not</u> view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>SPACIO V. PATRICK</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>2/11/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SPACIO V. PATRICK</b>   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>2-16-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON FORREST VET.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>GARRISON MARYLAND</b>                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E.L. PHILLIPS</b>  |  | ADDRESS<br><b>1721 N. MONROE ST. 21217</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1984</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |

BP

OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS



OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04590

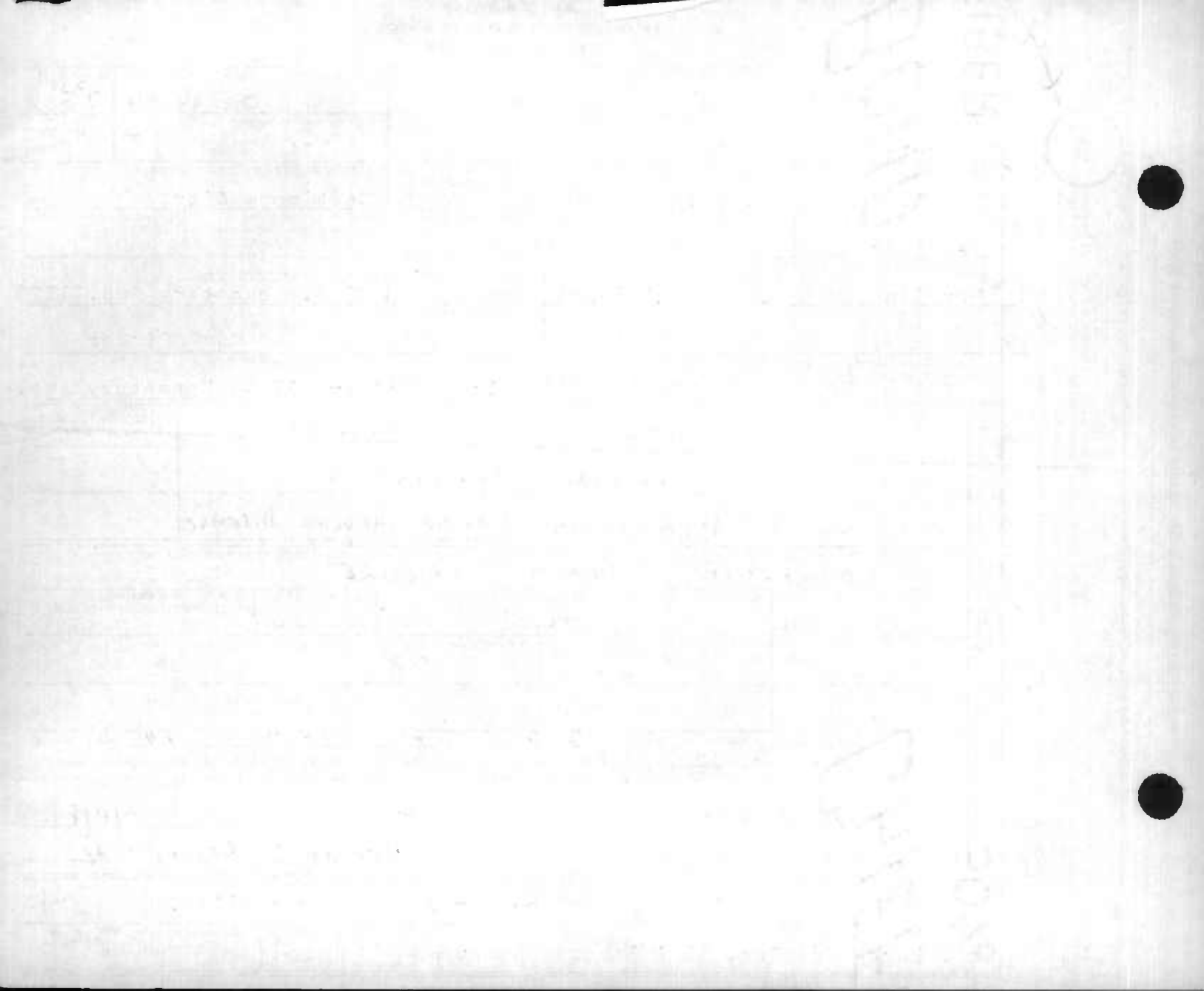
REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES J WILLIAMS</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02 14 84</b>  |  | 2b. HOUR<br><b>7<sup>30</sup> P M</b>  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 9 09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>37 N. Monastery Ave. 21229</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Williams</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Pinder</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>  |  |  |  |
|  |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-2626</b>   |  | 17. INFORMANT ADDRESS<br><b>Goldie Williams 37 N. Monastery Ave.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARRHYTHMIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>CONGESTIVE HEART FAILURE</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>NIL</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NIL</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>N/A</b> 19 <b>84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-2-</b> , 19 <b>84</b> , to <b>2-14-</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-14-</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Surjit</b>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>2/15/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURJIT</b>   |  | 22e. ADDRESS<br><b>JULKA</b>   |  | 22f. ADDRESS<br><b>BON SECOURS HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/21/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>   |  | 23d. LOCATION<br>(IF WORK TOWN) CITY OR TOWN COUNTY STATE<br><b>Cowhills Mills, MD.</b>                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Pendell</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Popul may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04591

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARET WILLIAMS</b> |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-27-84</b>                              |   | 2b. HOUR<br><b>10:10 PM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-8-7</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                       |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bow Secure Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> | 12b. KIND OF BUSINESS OR INDUSTRY                                     |   |
| 13a. STATE<br><b>md</b>  |   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES ?</b>                             |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SALLY RATTLIFF</b>             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>    |   | 16b. SOCIAL SECURITY NO.<br><b>220-30-1924</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JAMES T. MARSHALL 2808 The Alameda</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4360 Cerebrovascular Accident**

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE (a), (b), (c).

(b) **Cerebral Atherosclerosis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

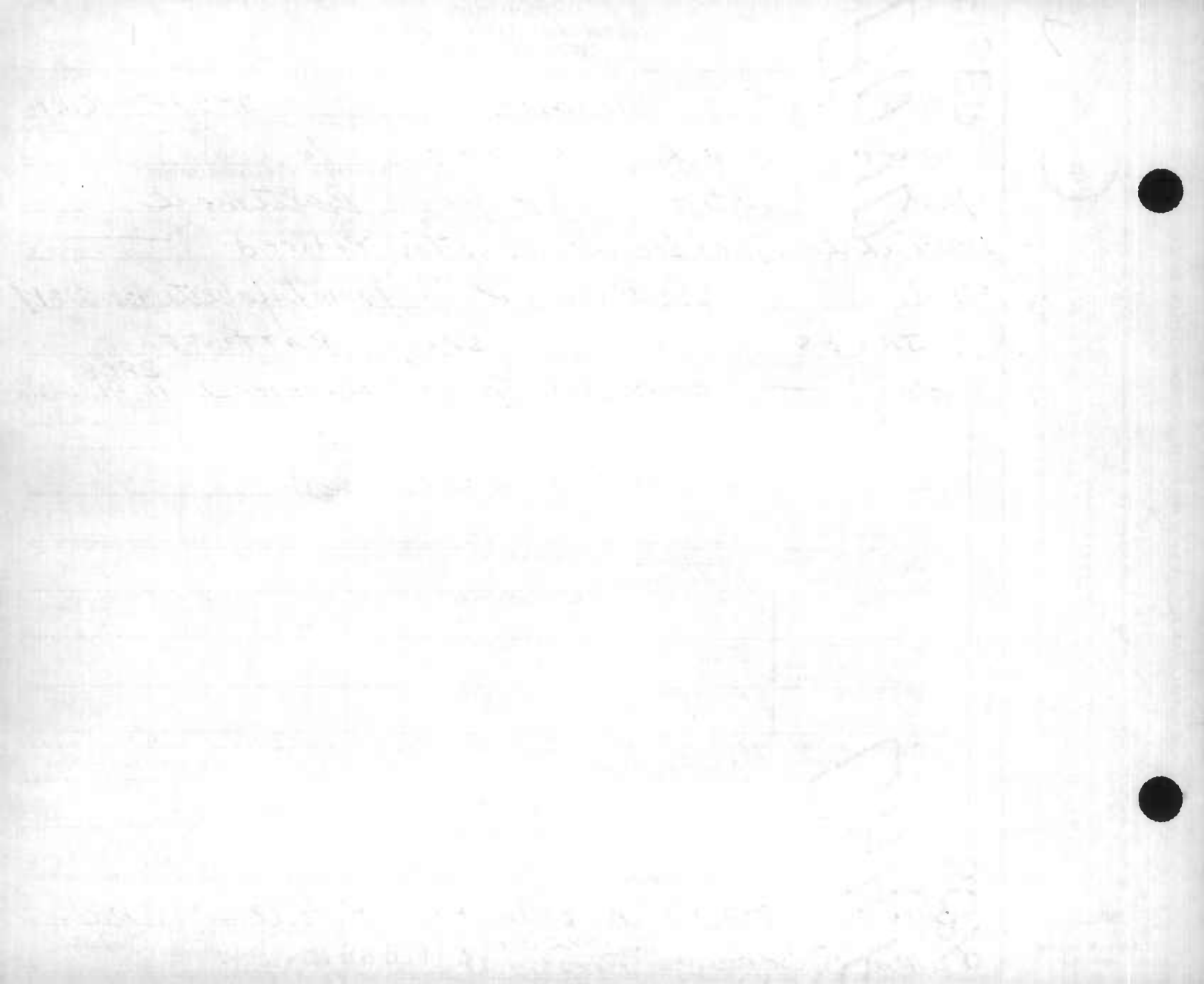
APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Diabetes Mellitus**

|  |  |   |  |
|--|--|---|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-4-1983</b> to <b>2-27-1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-27-1984</b> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>2/28</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PHMAN</b>  |  | 22e. ADDRESS<br><b>2717 - Hammond Ave. Kery Rd 21227</b>  |  |

|   |                            |  |   |
|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>3-2-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING MARY PK.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Calvin B. Scruggs</b>      |                            | ADDRESS<br><b>1412 E. Preston St.</b>                      | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 29 1984</b>                       |
|   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>           |   |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

04592

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Stanley H. Williams                  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02-16-84 |   |  | 2b. HOUR<br>10 P.M.   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>C White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-18-19  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan hosp. |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retailer                    |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Balt.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Stanley Williams                  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Loretta Getz   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 11  |   | 17. INFORMANT<br>ADDRESS<br>Charter Patient   |  |   |  |

|  |  |  |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Resp. Arrest.<br>1850<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Advanced metastatic Carcinoma of Prostate.<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/21/83 to 2/16/84, that (I) (we) lost saw the deceased alive on 2/16/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>B. Nolan  |  |  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>2/16/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bryan Nolan, M.D.  |  |  |  | 22e. ADDRESS<br>Good Samaritan hosp.   |  |  |  |

|   |  |                      |  |   |  |   |  |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                  |  | 23b. DATE<br>2/20/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem Park |  | 23d. LOCATION<br>Baltimore, Maryland STATE      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 21 1984            |  | 25b. REGISTRAR'S SIGNATURE<br>Julia [Signature] |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |   |  |  |
|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH S WILLS</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-22-84</b>                |  |   | 2b. HOUR<br><b>1:35 PM</b>   |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 19 10</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Wills</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Matilda Burch</b>   |   | 13e. STREET ADDRESS<br><b>21215 4137 Park Heights Avenue</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>705-09-6735</b>  |   | 17. INFORMANT ADDRESS<br><b>A Geraldine Wills 4137 Park Heights Ave</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>CARDIOPULMONARY ARREST</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b). <b>SMALL CELL CARCINOMA OF THE LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c).           |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 16</b> , 19 <b>84</b> , to <b>FEBRUARY 22</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>FEB. 22</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>C.C. ONEJEME</b>   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/22/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C.C. ONEJEME</b>  |  | 22e. ADDRESS<br><b>PROVIDENT HOSPITAL</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(S) <b>BURIAL</b>  |  | 23b. DATE<br><b>3/1/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lansdowne, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc. 1101 E. North Avenue</b>   |  |   |   | 25. DATE REC'D BY REGISTRAR<br><b>FEB 28 1984</b>  |   |  |  |

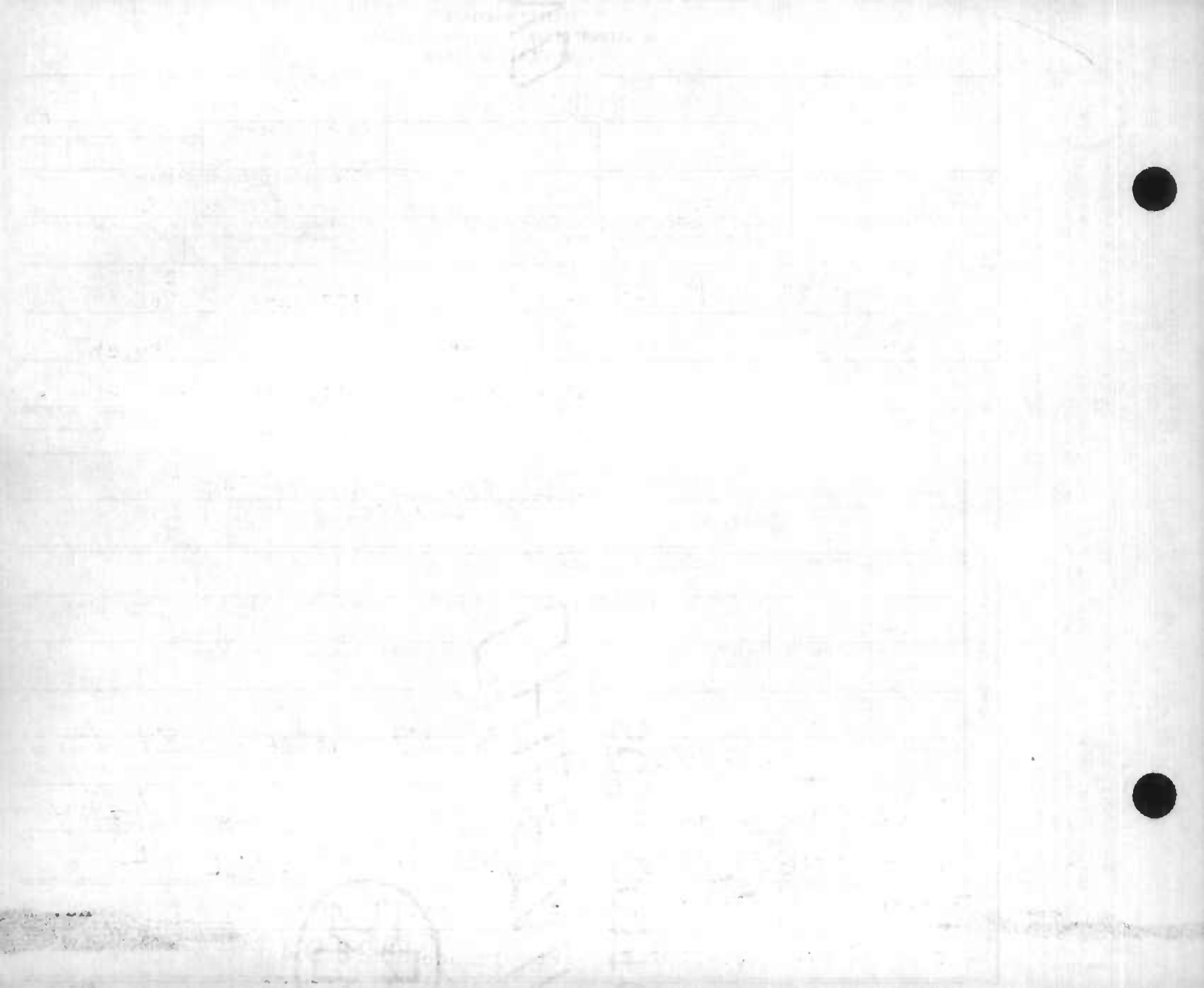
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes" (18 shows any injury, or other traumatic event), the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |                            |  |
|--|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES Willson</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-19-84</b> |   | 2b. HOUR<br><b>7:30p</b> M |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUC.</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 14 04</b>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  | 7. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>UNKNOWN</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b>  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNKNOWN</b>  |                            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>UNKNOWN</b>  |  | 13a. STATE<br><b>MARYLAND</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   |                            |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>3705 Norvania Road.</b>   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>  |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>212624637</b>   |  | 17. INFORMANT<br><b>Mr. Harry Arnett</b>   |   | ADDRESS<br><b>608 McPhael Rd. Bel Air, Md.</b>  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>congestion heart failure</b>   |  |  |   |   |                            |  |
| 19a. DATE OF OPERATION<br><b>2-10-84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>congestion heart failure</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                            |  |
| 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 21f. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>2-10-84</b> to <b>2-19-84</b> , that (I) (we) lost saw the deceased alive on <b>2-19-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br><b>McKethman</b>  |                            |  |
| 22c. DATE SIGNED<br><b>2/21/84</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. McKethman</b>   |   | 22e. ADDRESS<br><b>2717 - Hammonds Ferry Rd BALD MD</b>   |                            |  |
| 22f. DEGREE<br><b>MD</b>   |  | 22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   | 22h. DATE REC'D. BY REGISTRAR<br><b>FEB 28 1984</b>   |                            |  |
| 22i. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |   | 23b. DATE<br><b>2/22/84</b>   |                            |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   | 23e. NAME OF CEMETERY OR CREMATORY  |                            |  |
| 23f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |   | 24b. ADDRESS<br><b>Balto., Md.</b>  |                            |  |

11/11/13



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

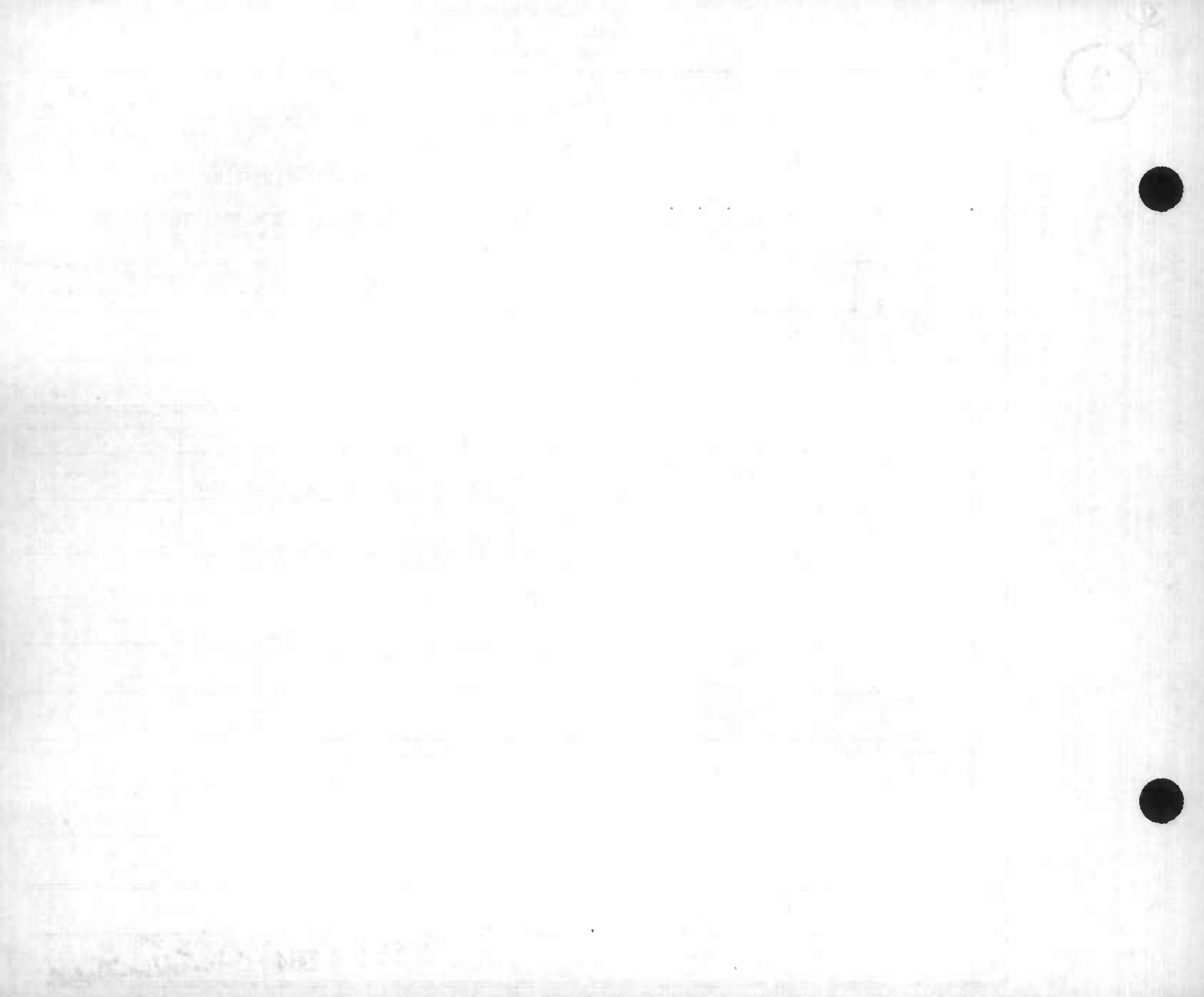
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 13, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |   |   |  |  |
|--|--|--|---|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 04595   |   |   |  |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>BEATRICE Wilson  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 12 84     |  |   | 2b. HOUR<br>6 <sup>55</sup> AM  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 15 07  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITALS |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland  |  |  |   |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore                                    |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST             |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>UNKNOWN   |  |  |   |   | 16b. SOCIAL SECURITY NO.<br>216-07-7950                |  | 17. INFORMANT ADDRESS<br>William H. Bell 2000 Odell Ave. Apt. 903 |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive RIGHT PLEURAL EFFUSION</u><br>5 months<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>METASTATIC LUNG CANCER</u><br>18 months<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> , 19 <u>84</u> , to <u>2/12</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2/12</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>George Markus</u>   |  |  | DEGREE<br>MD  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br>2/12/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George MARKUS   |  |  | 22e. ADDRESS<br>4940 Eastern Ave 21224                              |   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>2/16/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem. |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Cheltenham Md.         |   |  |  |
| 24. FUNERAL DIRECTOR<br>Wm C March F/H Inc. 1101 E North Avenue  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 14 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

Item 18 2/27/84 mtb F#588

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

0 4 5 9 6

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                      |   |   |  |  |  |   |  |
|---|----------------------|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DONNIE WILSON</b>  |                      |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2/5/84</b> 19       |  |  | 2b. HOUR <b>6:40</b> P M   |   |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 29 83</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>1</b> MONTHS <b>7</b> DAYS <b>7</b> HOURS <b>7</b> MIN.   | 7c. DATE PRONOUNCED DEAD <b>2/5/84</b> 19  | 7d. HOUR <b>6:40</b> P M   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto.</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.     |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> COUNTY <b>MD.</b>  |                      |   | 13c. CITY OR TOWN <b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2120 Barclay St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Donnie</b> MIDDLE <b>Wilson</b> LAST <b>Wilson</b>  |                      |   | 14. MOTHER'S MAIDEN NAME<br>FIRST <b>Rosemary</b> MIDDLE <b>Hutcherson</b> LAST <b>Hutcherson</b> |  |  |  |   |  |
| 15a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, OR UNKNOWN) <b>No</b>  |                      |   | 15b. SOCIAL SECURITY NO. <b>---</b>   |  |  | 15c. INFORMANT ADDRESS <b>Rosemary Hutcherson 2120 Barclay St.</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4660</b> IMMEDIATE CAUSE (a) <b>Acute bronchitis &amp; Bronchopneumonia</b><br><b>Sudden Infant Death Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>---</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b>   |                      |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                      |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>---</b> P.M. <b>---</b> 19 <b>---</b>          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |   |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>   |                      |   | TITLE (SPECIFY) <b>Dep. Chief</b>   |  |  | MEDICAL EXAMINER   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>  |                      |   | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |  |  | DATE SIGNED <b>2/6/84</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                      |   | 23b. DATE <b>2-10-84</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>      |   |  |
| 23d. LOCATION CITY OR TOWN <b>Anne Arundel</b>  |                      |   | 23e. COUNTY <b>Md.</b>  |  |  | 23f. STATE   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Carlton C. Douglas</b> ADDRESS <b>1012 Penn Ave.</b>  |                      |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>   |  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>              |   |  |

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 04597   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2 2 3 84  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry Wilson, Jr.  |  |  |  | 2b. HOUR 800 M.  |  |   |  |
| 3. SEX Male   |  | 4. RACE Negro  |  | 5. DATE OF BIRTH MONTH DAY YEAR 4 15 40  |  | 6. AGE (IN YEARS, LAST BIRTHDAY) 43 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BA Ht. City MD.  |  |
| 10. CITY OR TOWN OF DEATH Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. Mem. Hosp. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a. STREET ADDRESS / ZIP CODE 2301 Jopka Ave. 21225   |  |   |  |
| 13a. STATE MD   |  | 13b. COUNTY Balto. City  |  | 13c. CITY OR TOWN Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Wilson Sr.  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madeline Brace  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes   |  | 16b. SOCIAL SECURITY NO. 018-30-0755   |  | 17. INFORMANT ADDRESS Leo La Wilson 2301 Jopka Ave.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Septic shock<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Intraabdominal sepsia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Lung CA to metastasis |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from 2-1 19 84, to 2-3 19 84, that (we) last saw the deceased alive on Feb-3 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE Luis R. Ramos  |  |  |  | DEGREE   |  | 22c. DATE SIGNED 2-3-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis R. Ramos   |  |  |  | 22e. ADDRESS 3001 S Hanover St.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 2/8/84   |  | 23c. NAME OF CEMETERY OR CREMATORY Crownsville VA Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD  |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR FEB 6 1984   |  | 25b. REGISTRAR'S SIGNATURE  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, a copy of item 18 should accompany item 21.

DHMH - 16 50M 4/83  
(VRA 15, 4)

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |   |  |  |
|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James D. Wilson   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 26, 1984  |  |   | 2b. HOUR<br>4:48 M   |  |
| 3. SEX<br>M  | 4. RACE<br>B   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 7 11                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br># UNDER 24 HRS.<br>HOURS MIN.                                 |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hosp. |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dennis Wilson  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Della Carter   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212-16-8416                                |   | 17. INFORMANT<br>ADDRESS<br>Shirley B. Wilson 2505 W. Pratt St.                |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>45 min</u><br><u>2 hrs.</u> |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>2-26-84</u> , 19____, to <u>2-26-84</u> , 19____, that (we) lost<br>saw the deceased alive on <u>2-26-84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Scott D. Rowley, M.D.</u><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |   | 22c. DATE SIGNED<br><u>2-26-84</u>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Scott D. Rowley, M.D.</u>  |  |  |   | 22e. ADDRESS<br><u>Bon Secours Hosp. Baltimore, Md.</u>                        |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  | 23b. DATE<br>3/1/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Wilson Memorial Cem, Gambrills,          |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc, 1101 E North Avenue  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1984                                   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |                       |       |
|---|--|--|---|-----------------------|-------|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR              |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |   | MONTH DAY YEAR        |       |
| JOSEPH WILSON   |  | February 10, 1984  |   | 400 P M               |       |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR    |       |
| Male  | White  | Dec. 25, 1896  | 87 YRS.   | IF UNDER 24 HRS.      |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                       |       |
| Scotland  | USA  |  | Baltimore City MD.  |                       |       |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                       |       |
| Baltimore   | 373 Homeland Southway  | Restaurateur   | Restaurant 21212  |                       |       |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |       |
| MD  |  | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 373 Homeland Southway |       |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   |  |   |                       |       |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST  |  |   |                       |       |
| Unknown   | Unknown  |  |   |                       |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  |   | ADDRESS               |       |
| Yes   | WW I   | Mrs. Margaret L. Wilson,   |   | Same                  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic CARCINOMA OF the Bladder</u><br><u>1889</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |                       |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Hypertension - Aortic Stenosis</u>   |  |  |   |                       |       |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                       |       |
|   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                       |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                       |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |                       |       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY</u> , 19 <u>77</u> , to <u>2-3</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                       |  |  |   |                       |       |
| 22b. SIGNATURE  | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |   | 22c. DATE SIGNED      |       |
| <u>Dr. Miguel Karacuschansky</u>  |  |  |   | <u>2-13-84</u>        |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS   |  |   |                       |       |
| Dr. Miguel Karacuschansky, M.D.   | 300 E. 33rd St., Balto., MD  |  |   |                       |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN  | COUNTY                | STATE |
| Entombment  | 2/14/84  | Lorraine Maus.   | Balto.,   | MD                    | MD    |
| 24. FUNERAL DIRECTOR'S NAME   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |                       |       |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  | FEB 14 1984  |  | <u>J. Davidson-Randall</u>  |                       |       |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

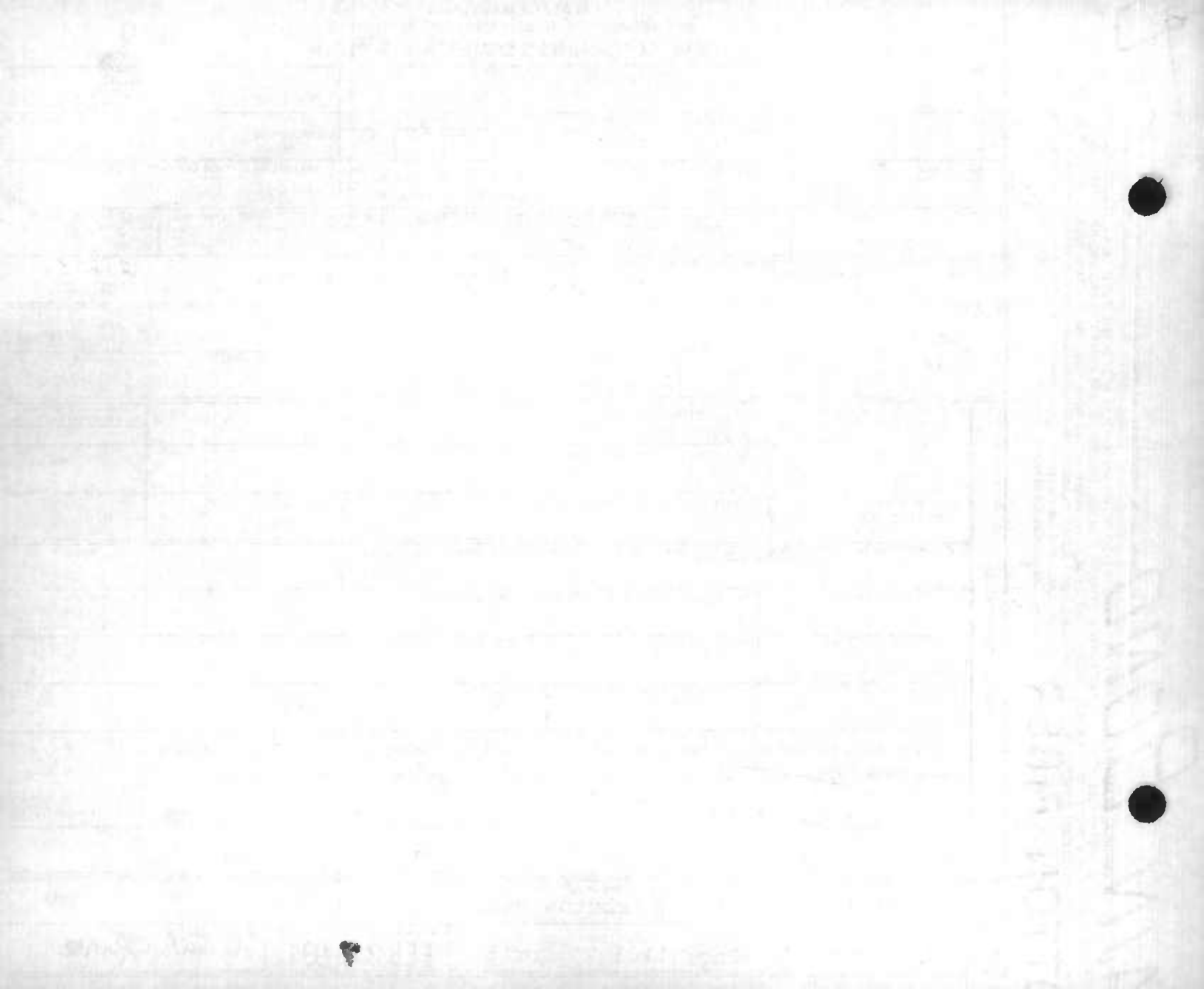
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04600

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |              |                |  |  |   |  |   |      |                                |  |   |  |  |                          |   |  |   |  |
|---|--|--------------|----------------|--|--|---|--|---|------|--------------------------------|--|---|--|--|--------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |              | FIRST<br>Louis |  |  | MIDDLE<br>Wilson                                |  |   | LAST |                                |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR         |  |  | 2b. HOUR<br>M            |   |  |   |  |
| 3. SEX<br>M   |  | 4. RACE<br>B |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 14 31  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>52 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |      | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 25 1984   |  |  | 2d. HOUR<br>a M<br>12:45 |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  |              |                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |                          |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |              |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>333 E. 20th Street |  |   |  |   |      |                                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |  |                          | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |   |  |
| 13a. STATE<br>MD  |  |              |                | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN<br>Baltimore  |      |                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                          | 13e. STREET ADDRESS<br>21218 Fenwick Avenue               |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unkn  |  |              |                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie Wilson  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |      |                                |  | 16b. SOCIAL SECURITY NO.<br>218-26-9702   |  |  |                          | 17. INFORMANT ADDRESS<br>Dorothy Wilson 2718 Fenwick Ave, |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u><br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |              |                |  |  |   |  |   |      |                                |  |   |  |  |                          |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |              |                |  |  |   |  |   |      |                                |  |   |  |  |                          |   |  |   |  |
| 19a. DATE OF OPERATION  |  |              |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |      |                                |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |                          |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |              |                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |      |                                |  |   |  |  |                          |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |              |                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |      |                                |  |   |  |  |                          |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .               |  |              |                |  |  |   |  |   |      |                                |  |   |  |  |                          |   |  |   |  |
| ACTUAL SIGNATURE<br><u>Thomas D. Smith</u>  |  |              |                | TITLE (SPECIFY)<br>M.D. Deputy Chief   |  |   |  | DATE SIGNED<br>2/25/84  |      |                                |  | MEDICAL EXAMINER  |  |  |                          |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |              |                | ADDRESS<br>111 Penn St. Balto., MD.  |  |   |  |   |      |                                |  |   |  |  |                          |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |              |                | 23b. DATE<br>3/1/84  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.  |      |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus MD  |  |  |                          |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H, Inc.  |  |              |                |  |  |   |  |   |      |                                |  | ADDRESS<br>1101 E. North  |  |  |                          | 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1984              |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u> |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |              |  |                                    |   |                  |   |          |   |  |
|---|--|--|--------------|--|------------------------------------|---|------------------|---|----------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST OLIVIA   | MIDDLE E. E. | LAST WILSON  | 2. DATE OF DEATH<br>MONTH DAY YEAR |   | FEBRUARY 19 1984 |   | 2b. HOUR |   |  |
| 3. SEX  |  | FEMALE   |              | 4. RACE  |                                    | NEGRO   |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |          | MAY 20 1918                                       |  |
| 6. AGE<br>(IN YEARS LAST BIRTHDAY)  |  | 65   |              | 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |                                    | VIRGINIA  |                  | 7b. CITIZEN OF WHAT COUNTRY?  |          | USA   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |              | 10. CITY OR TOWN OF DEATH  |                                    | Balto   |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                       |          | Granada N.H.                                      |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | NURSE  |              | 12b. KIND OF BUSINESS OR INDUSTRY  |                                    |   |                  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |          | 13b. STREET ADDRESS                               |  |
| 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13b. STREET ADDRESS  |              | 13c. CITY OR TOWN  |                                    | BALTIMORE   |                  | 14. FATHER'S NAME<br>(TYPE OR PRINT)  |          | THOMAS  |  |
| 14. FATHER'S NAME<br>(TYPE OR PRINT)  |  | THOMAS   |              | 15. MOTHER'S MAIDEN NAME<br>(TYPE OR PRINT)  |                                    | JULIA E. GODWIN   |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |          | NO  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | NO   |              | 16b. SOCIAL SECURITY NO.   |                                    | 578-42-5675   |                  | 17. INFORMANT'S NAME<br>(TYPE OR PRINT)   |          | MARION MIDDLEBROOKS                               |  |
| 17. INFORMANT'S NAME<br>(TYPE OR PRINT)   |  | MARION MIDDLEBROOKS  |              | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Primary Degenerative Dementia</u><br>2989<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Depression</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |                                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                  | 19a. DATE OF OPERATION  |          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                  | 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                                    | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                       |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                    | 22a. I certify that (I) (this hospital) attended the deceased from<br>above (I) (we) (did) (did not) view the body after death. |                  | 22b. SIGNATURE<br>(TYPE OR PRINT)   |          | 22c. DATE SIGNED                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>above (I) (we) (did) (did not) view the body after death.                             |  | 22b. SIGNATURE<br>(TYPE OR PRINT)                                      |              | 22c. DATE SIGNED   |                                    | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |                  | 22e. ADDRESS  |          | 22f. DATE SIGNED                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |              | 22f. DATE SIGNED   |                                    | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |                  | 23b. DATE   |          | 23c. NAME OF CEMETERY OR CREMATORY                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |              | 23c. NAME OF CEMETERY OR CREMATORY   |                                    | 23d. LOCATION   |                  | 23e. NAME OF CEMETERY OR CREMATORY  |          | 23f. LOCATION                                     |  |
| 23d. LOCATION   |  | 23e. NAME OF CEMETERY OR CREMATORY                                     |              | 23f. LOCATION  |                                    | 24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT)   |                  | 24b. ADDRESS  |          | 25a. DATE REC'D. BY REGISTRAR                     |  |
| 24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT)   |  | 24b. ADDRESS   |              | 25a. DATE REC'D. BY REGISTRAR  |                                    | 25b. REGISTRAR'S SIGNATURE  |                  | 25c. DATE REC'D. BY REGISTRAR   |          | 25d. REGISTRAR'S SIGNATURE                        |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

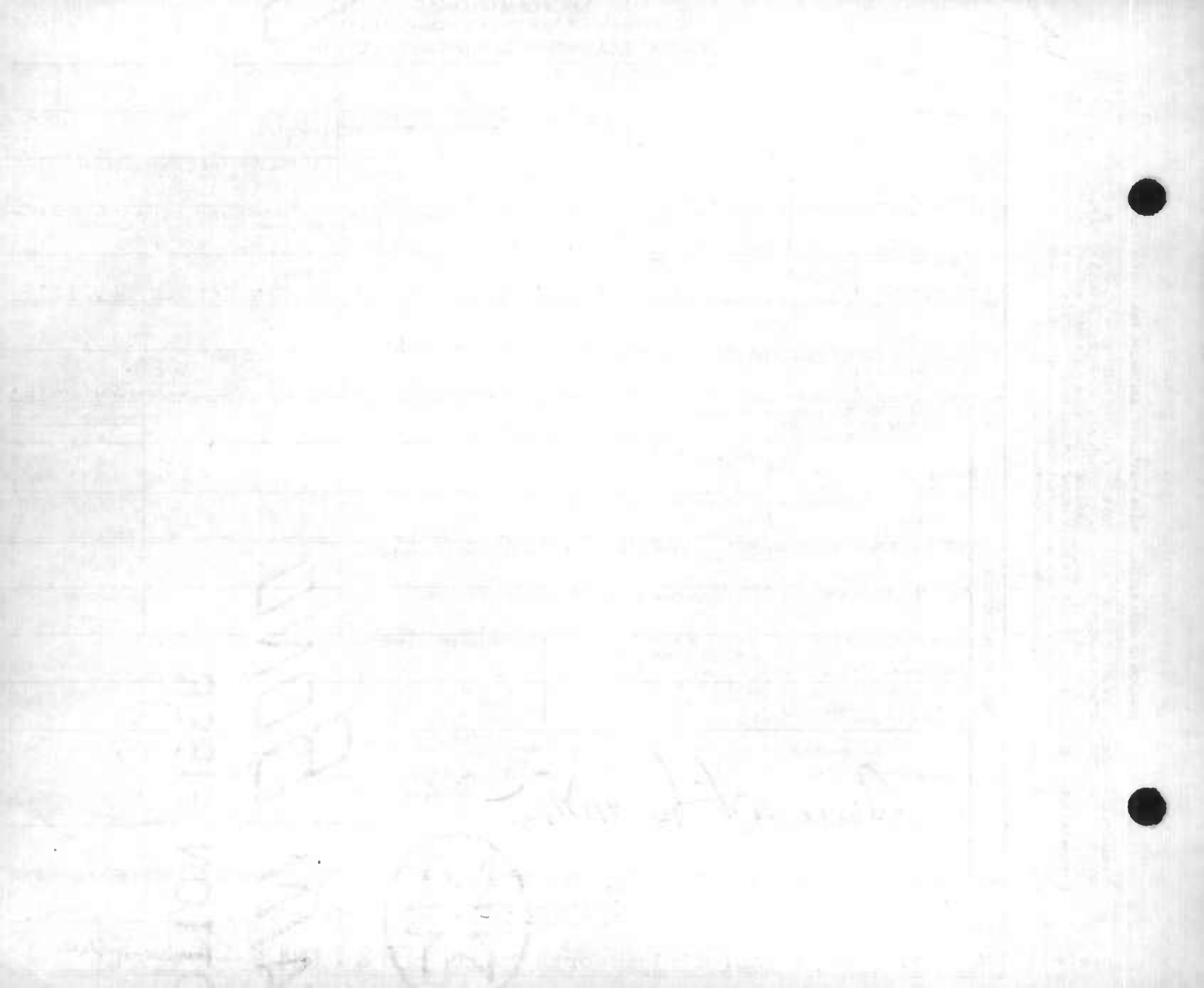


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1.1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (S))  
20M 4/82

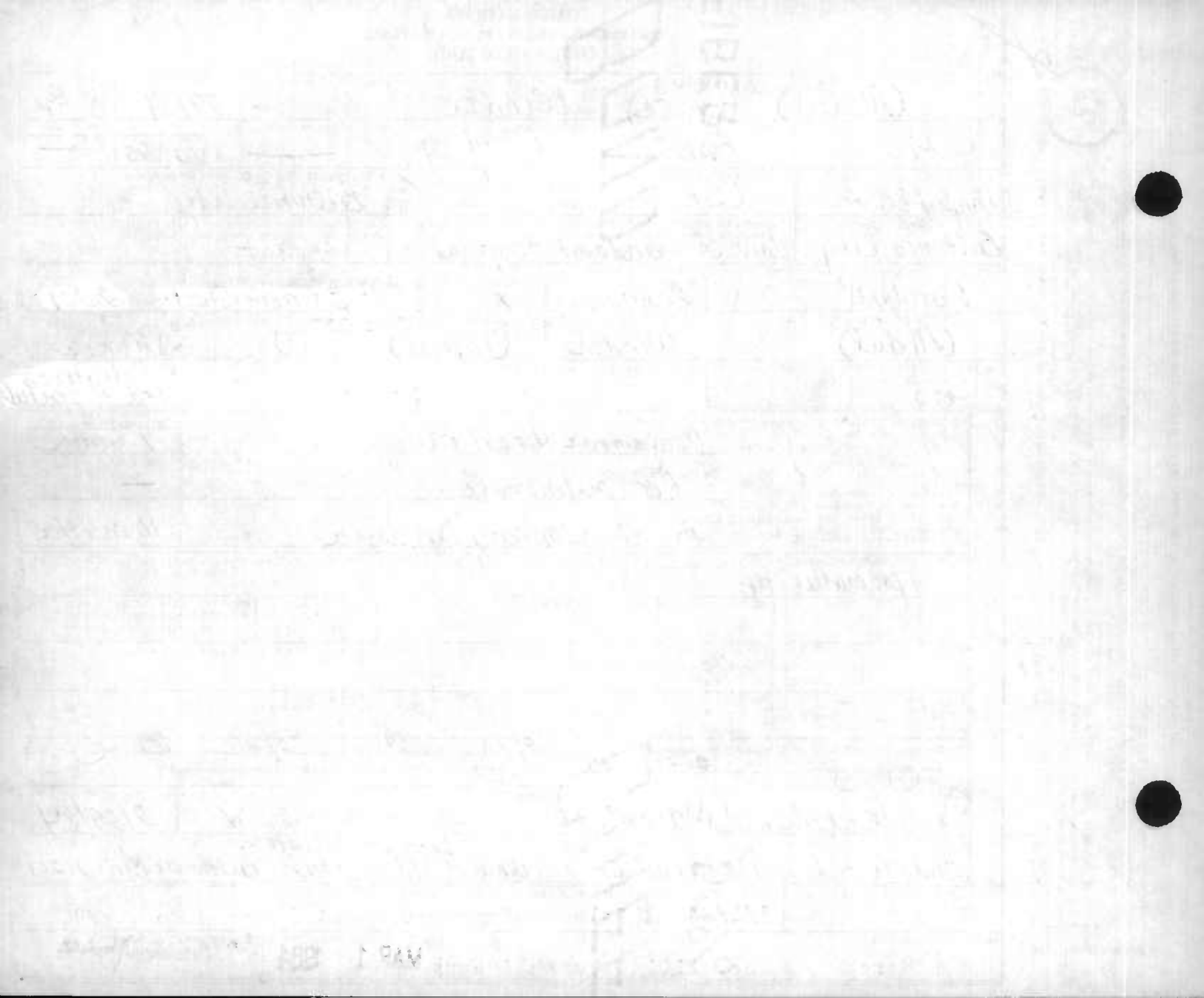
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |         |   |  |  |  |   |  |                                      |  | 0 4 6 0 2                                    |  |
|--|---------|---|--|--|--|---|--|--------------------------------------|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |  |  |  |   |  |                                      |  | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH MATED        |  | XX MONTH DAY YEAR                            |  |
| Randolph   |         | Wilson  |  |  |  |   |  | 2-19 19 84                           |  | 7b. HOUR                                     |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR   |  | IF UNDER 24 HRS                      |  | 7c. DATE PRONOUNCED DEAD                     |  |
| Male   | Black   | 6 28 65   |  | 18 YRS.  |  |   |  |                                      |  | 2-19 19 84                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | MD.  |  |
| Maryland   |         | U.S.A.  |  |  |  |   |  | Baltimore City.                      |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |  |  |
| Baltimore  |         | 2900 Blk. Ellicott Dr.-on street                            |  |  |  |   |  |                                      |  |  |  |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |  |  |
| Maryland   |         |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2938 Winchester St. 21216            |  |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                        |  | ADDRESS                                      |  |
| William  |         | Deborah   |  | NO   |  |   |  | Deborah Wilson                       |  | Apt. T                                       |  |
|  |         |   |  |  |  |   |  | 2956 Garrison Blvd.                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |  |  |   |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |         |   |  |  |  |   |  |                                      |  |  |  |
| IMMEDIATE CAUSE (a) Shotgun Wound of Chest   |         |   |  |  |  |   |  |                                      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |  |  |   |  |                                      |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |   |  |  |  |   |  |                                      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |  |  |   |  |                                      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |  |  |   |  |                                      |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |   |  |  |  |   |  |                                      |  |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?   |  |   |  |                                      |  |  |  |
|  |         |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |                                      |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |                                      |  |  |  |
|  |         | 11:39 P.M. 2-19 19 84                                       |  | subject was shot   |  |   |  |                                      |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY                               |  | STATE  |  |
|  |         | street  |  | 2900 Blk. Ellicott Dr., Balto., Md.  |  |   |  |                                      |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |  |  |   |  |                                      |  |  |  |
| ACTUAL SIGNATURE   |         |   |  |  |  |   |  |                                      |  | TITLE (SPECIFY)                              |  |
|  |         |   |  |  |  |   |  |                                      |  | M.D. Assistant MEDICAL EXAMINER              |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   |  |  |  |   |  |                                      |  | DATE SIGNED                                  |  |
| Dennis F. Smyth, M.D.  |         |   |  |  |  |   |  |                                      |  | 2-20-84                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | COUNTY                               |  | STATE  |  |
| BURIAL   |         | 2/24/84   |  | Baltimore Cemetery   |  | Baltimore,  |  |                                      |  | Md.  |  |
| 24. FUNERAL DIRECTOR   |         |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE           |  |  |  |
| Wm C March F/H Inc. 1101 E North Avenue  |         |   |  |  |  | FEB 21 1984   |  | Julia Davidson-Randall               |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | REG. NO.   |  |
|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> <u>ABDULQAWER</u> <sup>MIDDLE</sup> <u>M.</u> <sup>LAST</sup> <u>Winder</u>   |  |  |  |  | 2a. DATE OF DEATH MONTH <u>2</u> DAY <u>29</u> YEAR <u>84</u>                      |  |
| 3. SEX <u>M</u>   |  | 4. RACE <u>Black</u>   |  | 5. DATE OF BIRTH MONTH <u>4</u> DAY <u>5</u> YEAR <u>83</u>                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland-USA</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 8. AGE (IN YEARS LAST BIRTHDAY) UNDER 1 YEAR <u>10</u> YEARS <u>25</u>         |  |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore City</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Univ. of Maryland Hospital</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Infant</u>    |  |  |
| 13a. STATE <u>Maryland</u>  |  | 13b. CITY OR TOWN <u>Baltimore</u>   |  | 13c. STREET ADDRESS / ZIP CODE <u>1759 Gorsuch Avenue 21218</u>                |  |  |
| 14. FATHER'S NAME <u>CHESTER</u> <sup>FIRST</sup> <u>(Abdul)</u> <sup>MIDDLE</sup> <u>Winder</u> <sup>LAST</sup> <u>Jr.</u>   |  | 15. MOTHER'S MAIDEN NAME <u>WATHANE</u> <sup>FIRST</sup> <u>(Daphne)</u> <sup>MIDDLE</sup> <u>W</u> <sup>LAST</sup> <u>Shines</u>        |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>   |  | 16b. SOCIAL SECURITY NO. <u>N/A</u>  |  | 17. INFORMANT ADDRESS <u>Chester Winder, Jr. 1759 Gorsuch Avenue</u>           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>7707</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cor pulmonale</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchopulmonary Dysplasia</u>   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 month</u><br><u>10 months</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>prematurity</u>   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> , 19 <u>84</u> , to <u>2/29</u> , 19 <u>84</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>2/29</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |
| 22b. SIGNATURE <u>Judith Rubin DeJarnette</u>   |  | DEGREE   |  | 22c. DATE SIGNED <u>2/29/84</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Judith Rubin DeJarnette</u>  |  | 22e. ADDRESS <u>Dept of Pediatrics Univ. of Md Hospital Baltimore Md 21201</u>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>   |  | 23b. DATE <u>3/1/84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Islamic Cemetery</u>                     |  |  |
| 24. FUNERAL DIRECTOR NAME <u>Wm C March F/H Inc.</u>  |  | ADDRESS <u>1101 E North Avenue</u>   |  | 25a. DATE REC'D. BY REGISTRAR <u>MAR 1 1984</u>                                |  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Davidson-Rendell</u>                             |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04604

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |       |   |      |  |  |                                   |  |                               |  |
|--|--|---|-------|---|------|--|--|-----------------------------------|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)          |  |   | FIRST | MIDDLE  | LAST | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  |                                   |  | 2b. HOUR                      |  |
| DIANE Marie Winebrenner                      |  |   |       |   |      | 02/06/84   |  |                                   |  | 3:50P                         |  |
| 3. SEX                                       |  | 4. RACE   |       | 5. DATE OF BIRTH  |      | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| Female                                       |  | White   |       | March 17, 1949  |      | 34   |  | YRS.                              |  |                               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |                                   |  |                               |  |
| Md   |  | USA   |       |   |      | Baltimore MD.  |  |                                   |  |                               |  |
| 10. CITY OR TOWN OF DEATH                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       |   |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                               |  |
| Baltimore                                    |  | The Johns Hopkins Hospital  |       |   |      | Homemaker  |  | Own Home                          |  |                               |  |

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13c. STREET ADDRESS, ZIP CODE                                    |  |  |
| 13a. STATE  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN  |  |  |
| Md  |  |  | Allegany  |  |  | Lonaconing   |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |
| Clarkson  |  |  | Dunn Jr.  |  |  | Florence Marie Loar  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                    |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT  |  |  |
| No  |  |  | None  |  |  | Mrs. Florence M. Brady, 1129 Dogwood Ct<br>Cumberland, Md. 21502 |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                              |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST                                     |  | 600 sec   |  |
| 4241<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | 10-12 days                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) SEPTIC SHOCK  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  
SYSTEMIC LUPUS ERYTHEMATOSUS UPPER G.I. BLEEDING

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 1/25/84   |  | ACUTE AORTIC INSUFFICIENCY   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25/84 to 2/6/84, that (I) (we) last saw the deceased alive on 2/6/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| Charles J. Cousar   |  | MD   |  |  |  | 2/6/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| C.J. COUSAR   |  |  |  | JOHNS HOPKINS HOSP.  |  |  |  |

|  |  |           |  |                                    |  |  |  |
|--|--|-----------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial                                       |  | Feb. 1984 |  | Mt. View Cemetery                  |  | Moscow Allegany Md.                        |  |
| 24. FUNERAL DIRECTOR<br>NAME                 |  |           |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE                 |  |
| Gwynn A. Eickhorn                            |  |           |  | FEB 14 1984                        |  | Julia Davidson-Randall                     |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                |  |  |   |   |  |  |   |  | REG. NO. 04605  |  |               |
|---|----------------|--|--|---|---|--|--|---|--|---|--|---------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>EDWARD E. WING  |                |  |  |   |   |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>2-24-84 |  | 2b. HOUR<br>M |
| 3. SEX<br>MALE  | 4. RACE<br>COL | 5. DATE OF BIRTH MONTH DAY YEAR<br>6-12-1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.                                    | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>2-24-84  |  | 2d. HOUR<br>8:50A   |  |   |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |  |   |  |               |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |               |
| 13a. STATE<br>MARYLAND  |                | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>847 GLENWOOD AVE 21212                                       |  |   |  |               |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>UNKNOWN  |                |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UNKNOWN                         |   |  |  |   |  |   |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO  |                | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br>Mrs Frances Martin 1800 W. ... 21217                                |  |   |  |   |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |                |  |  |   |   |  |  |   |  |   |  |               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |                |  |  |   |   |  |  |   |  |   |  |               |
| 19a. DATE OF OPERATION  |                |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |               |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |  |   |  |   |  |               |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |  |  |   |  |   |  |               |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                |  |  |   |   |  |  |   |  |   |  |               |
| ACTUAL SIGNATURE<br>Margarita A. Korell   |                |  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                            |   |  |  | DATE SIGNED<br>2-24-84  |  |   |  |               |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |                |  |  | ADDRESS<br>111 Penn Street  |   |  |  |   |  |   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                | 23b. DATE<br>2-29-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cem.                           |   | 23d. LOCATION CITY OR TOWN COUNTY<br>Pikesville Md   |  |   |  |   |  |               |
| 24. FUNERAL DIRECTOR NAME<br>Joseph L. Russ   |                |  |  | ADDRESS<br>2222 W. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                |  |   |  |               |



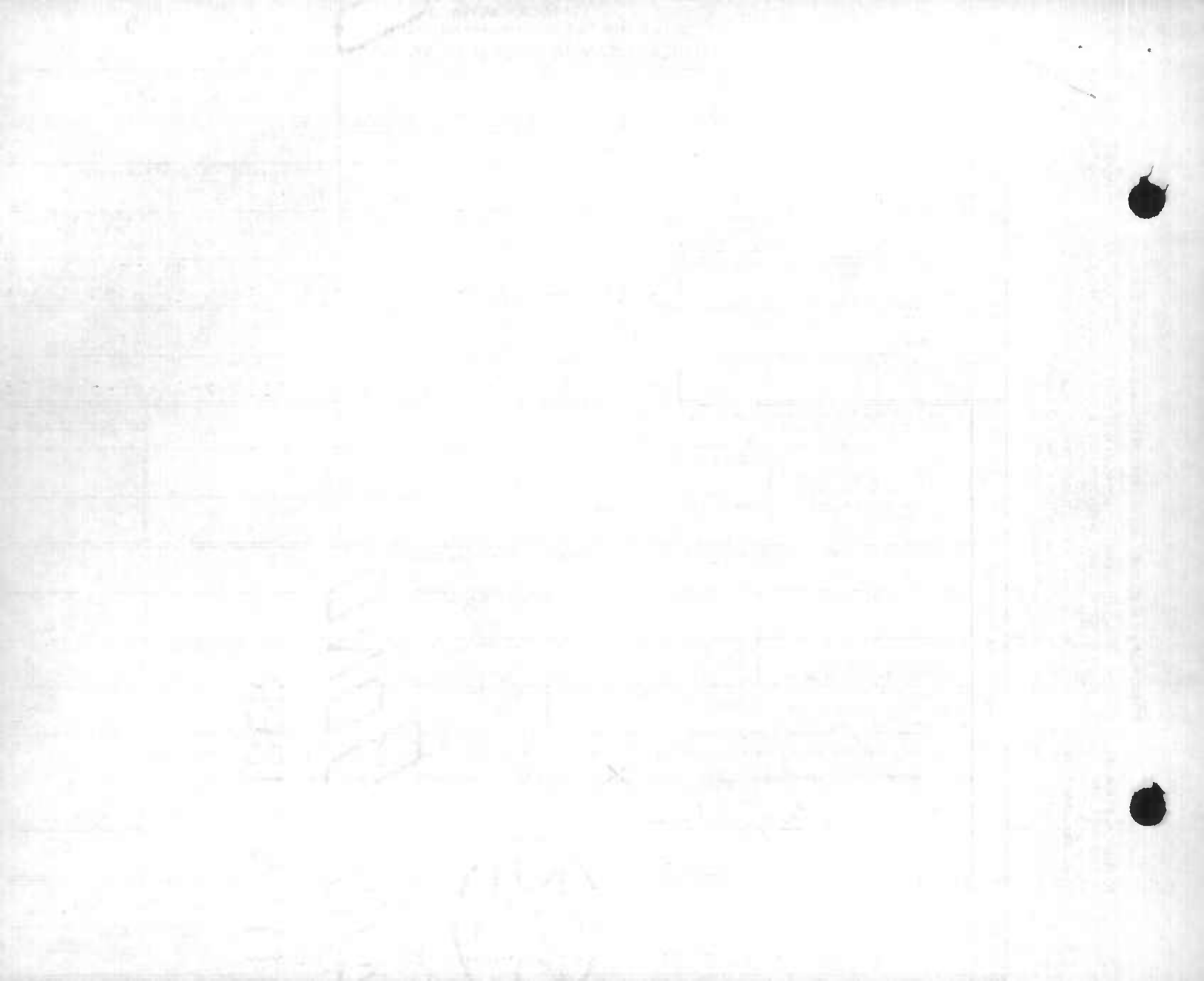
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                  |  |   |   |                                |  |  |  |  |   |  |                          |  |
|--|------------------|--|---|---|--------------------------------|--|--|--|--|---|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                  | FIRST  |   | MIDDLE  |                                | LAST   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 2/27/84<br>DEATH MATED <input type="checkbox"/> |  | MONTH DAY YEAR                                    |  | 2b. HOUR<br>12:20<br>A M |  |
| Odell  |                  | Winkey   |   |   |                                |  |  |  |  |   |  |                          |  |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 10 57  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>26 YRS. | IF UNDER 1 YR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7c. DATE PRONOUNCED DEAD<br>2/27/84                            |  | MONTH DAY YEAR   |  | 2d. HOUR<br>12:20<br>A M                          |  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City         |  |  |  |   |  | MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |   |  |                          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  | 13a. STATE<br>Maryland   |   | 13b. COUNTY   |                                | 13c. CITY OR TOWN<br>Baltimore                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 13e. STREET ADDRESS<br>5223 Reistertown Rd 2nd Fl |  | 21215                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Winkey, Sr.   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alease Hairston   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |                                | 16b. SOCIAL SECURITY NO.<br>215-74-5849                        |  | 17. INFORMANT<br>Timothy Winkey  |  | ADDRESS<br>5223 Reisterstown Rd                   |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). Gunshot wound to chest<br>9229<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b).<br>(c).   |                  |  |   |   |                                |  |  |  |  |   |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |  |   |   |                                |  |  |  |  |   |  |                          |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                |  |  |  |  |   |  |                          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>11:15 PM 2/26/84  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)<br>subject shot   |                                |  |  |  |  |   |  |                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>5200 Blk. of Linden Hgt. Ave., Balto City, Md.   |                                |  |  |  |  |   |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |  |   |   |                                |  |  |  |  |   |  |                          |  |
| ACTUAL SIGNATURE<br>   |                  | TITLE (SPECIFY)<br>M.D. Assistant  |   | MEDICAL EXAMINER  |                                | DATE SIGNED<br>2/27/84   |  |  |  |   |  |                          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |                  | ADDRESS<br>111 Penn St., Balto. Md. 21201  |   |   |                                |  |  |  |  |   |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |                  | 23b. DATE<br>3/2/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown Md. |  |  |  |   |  |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc.  |                  | ADDRESS<br>1101 E North Avenue   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 28 1984  |                                | 25b. REGISTRAR'S SIGNATURE<br>                                 |  |  |  |   |  |                          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | REG. NO.<br>04607                            |  |          |  |
|--|--|--|--|---|--|---|--|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  | 2a. DATE OF DEATH   |  |  |  |  |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Bertha C. Winston  |  |  |  |   |  | MONTH DAY YEAR<br>2 16 84   |  |  |  |  |  | 6:5 A.M. |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 11 1891  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.                                    |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                    |  |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Keowuk Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home    |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>4558 The Strand 21215 |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Woods   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fannie Woods   |  |   |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>220 44 9237   |  | 17. INFORMANT<br>Beatrice Walker  |  |  |  | ADDRESS<br>500 W. 140 St., N.Y., N.Y. 10031  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD with Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>INSTANT<br>5 wks<br>4 yrs |  |  |  |   |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 16 Feb 1984 to 16 Feb 1984, that (I) (we) lost saw the deceased alive on 16 Feb 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br>Richardson M.D.  |  |  |  | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>16 Feb 84  |  |  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |   |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/20/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cemetery  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Md.   |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>Natter, and Sons<br>Funeral Home, Inc.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br>25c. REGISTRAR'S NAME<br>Gwynns Falls Pkwy<br>Baltimore, Md.<br>FEB 21 1984                  |  |   |  |  |  |  |  |          |  |

Hester and Sons  
General Home, Inc.

5501 Gwynn Falls Hwy  
Baltimore, Md.

Serial 2780784      Mr. Calvary Gregory      Anne Arundel Co.

NOTED  
10-17-64

10031

250 44 5233      Beatrice Walker      500 W. 140 St., N.Y., N.Y.

Samuel

James

Female

Woods

Myland

Baltimore

2

444 The Strand 21215

Harling Home

Homeowner

Home

Virginia

U.S.A.

2

Black

Dec. 11 1963

25

Female



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04508

1- FOR  
STATE  
REGISTRAR

REG. NO.

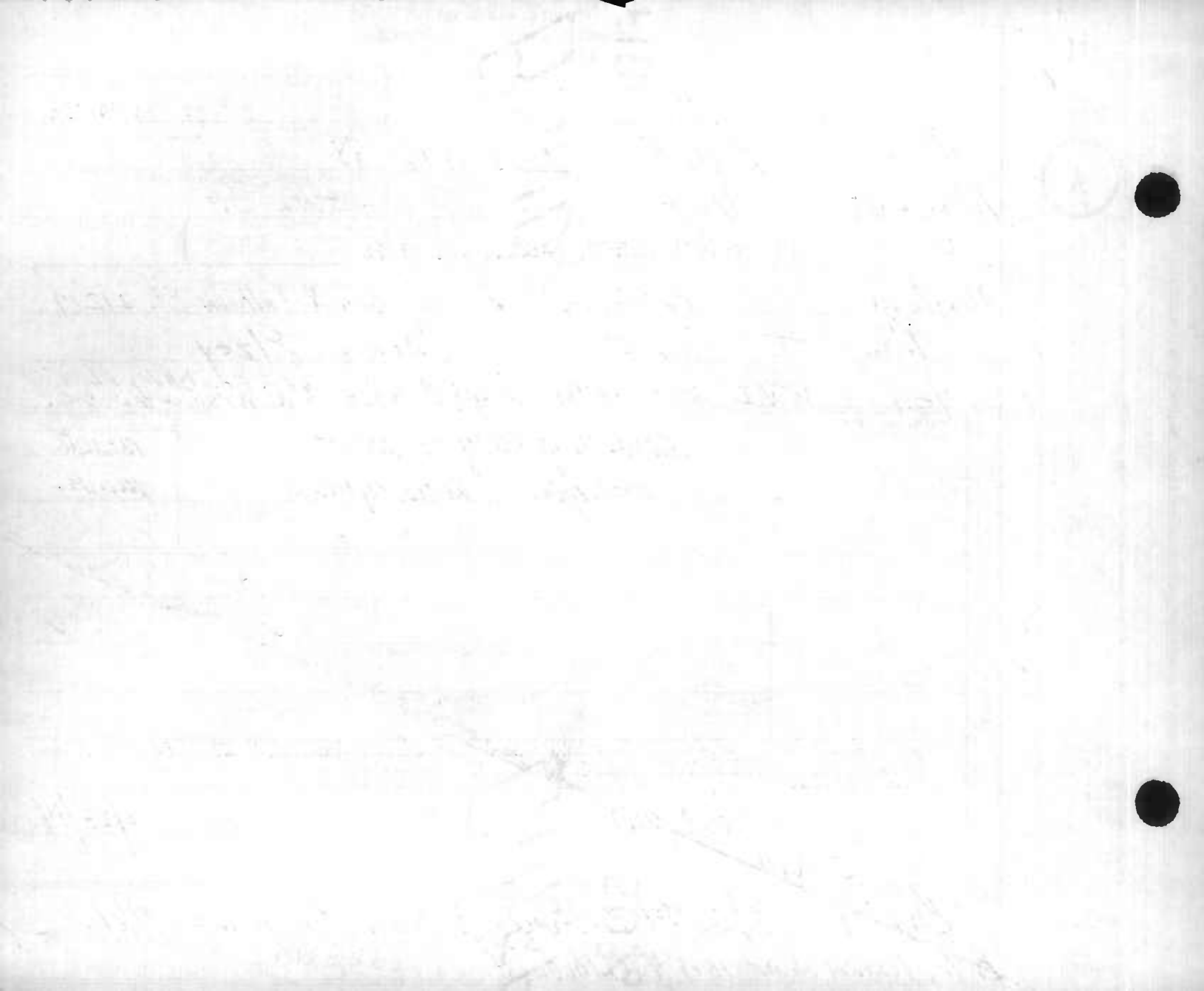
|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RAYMOND C. WISE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 27 84</b>                |  | 2b. HOUR<br><b>9:45a M</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 8 1896</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>                         |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.    |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER, BALTO., MD. 21218</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>   |  |   | 13c. COUNTY<br><b>Baltimore</b>                                      |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John T. WISE</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE Elzey</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-12-3781</b>                       |  |   |
| 17. INFORMANT<br>NAME ADDRESS<br><b>Joseph E. Wise 1402 F. Davis Place<br/>S.W. Washington, D.C.</b>  |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>malignant Reticulo cytoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1991</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>months</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEBRUARY 8</b> , 19 <b>84</b> , to <b>FEBRUARY 27</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>FEBRUARY 27</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>J. Reilly</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>2/28/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Reilly</b>   |  | 22e. ADDRESS  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>3/2/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Bailey Funeral Home</b>  |  | ADDRESS<br><b>1348 N. Calhoun St.</b>   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 29 1984</b>       |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |  |   |   |   | REG. NO.  |  |
|---|--|--|---|---|--|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rosa Witherspoon |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2-19-84                                       |   |   | 2b. HOUR<br>11:48 AM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>1-13-17  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS  |   | IF UNDER 1 YEAR MONTHS DAYS                                   |   | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SC   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. City MD.                                      |   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS HOSP. |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>2541 W. Lombard St 21223    |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Otis Lawson  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Esther Ragin  |  |  |   | ADDRESS<br>2541 West Lombard St. 21223                        |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>216-30-8397  |   | 17. INFORMANT<br>Hugh Witherspoon   |  |  |   | ADDRESS<br>2541 West Lombard St. 21223                        |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 CARDIAC ARREST (V. TACH. → STRAIGHT LINE) MINUTES<br>DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE ACUTE MYOCARDIAL INFARCTION HOURS<br>DUE TO, OR AS A CONSEQUENCE OF (c) 1+ ASCVD WITH OLD MI (11/80) YEARS |  |  |   |   |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS  |  |  |   |   |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |   |   |  |
| 22a. I certify that (this hospital) attended the deceased from 8-3, 19 81 to 2-19, 19 84, that (we) last saw the deceased alive on 2-19, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |   |   |   |   |  |
| 22b. SIGNATURE OF PHYSICIAN<br>William R. Law, M.D.   |  |  |   | DEGREE  |  |  |   | 22c. DATE SIGNED<br>2-19-84                                   |   | 22d. ADDRESS<br>BON SECOURS HOSPITAL<br>2000 W. BALTIMORE ST. BALTO. MD 21223 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>2-23-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.                         |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Arbutus Balto. MD. |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Shas.A. Rice FSPA 1300 Eutaw Place   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 23 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell          |   |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04610

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |
|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDWARD — WITHROW  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 24 84  |   | 2b. HOUR<br>12:30 PM   |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 29 44   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>39<br>YRS.   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TRUCK DRIVER  | 12b. KIND OF BUSINESS OR INDUSTRY<br>TRUCKING   |  |
| 13a. STATE<br>MD   | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>Middle River   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>10135 BIRDRENER RD 21220                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWARD — WITHROW   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Veronica — GUTRIDGE  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1963   |   | 17. INFORMANT<br>ADDRESS<br>ANNA WITHROW 10135 BIRDRENER RD                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY</u><br><u>1869</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>BLEOMYCIN TOXICITY OF LUNG (DUE TO</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>TESTICULAR CANCER. (CHEMO.)</u>   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c.   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 6</u> , 19 <u>84</u> , to <u>Feb. 24</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>Feb. 24</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |
| 22b. SIGNATURE<br><u>ARIF HUSSAIN</u>  |   | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |   | 22c. DATE SIGNED<br>2/24/84  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ARIF HUSSAIN  |   | 22e. ADDRESS<br>22 S. GREENE ST, BALTIMORE MD   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(Burial)  | 23b. DATE<br>2/27/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Memorial Gardens   |   | 23d. LOCATION<br>CITY OR TOWN BALTIMORE COUNTY Co., Md. STATE                        |
| 24. FUNERAL DIRECTOR<br>E. S. Szymanski<br>Szymanski Funeral Home  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1984  |   | 25b. REGISTRAR'S SIGNATURE<br>Lisa Davidson-Randall                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner should be notified.

3

24 84 12:00

W. J. W. 12:00

W. J. W. 12:00

U. S. A.

U. S. A. 12:00

U. S. A. 12:00

U. S. A. 12:00

U. S. A. 12:00

U. S. A.

U. S. A. 12:00

(Name)

U. S. A. 12:00

U. S. A. 12:00

U. S. A. 12:00

U. S. A. 12:00

U. S. A. 12:00

U. S. A. 12:00

U. S. A. 12:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |   |
|--|--|---|--|---|--|---|--|--|---|
| 1- FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>BB Woodard   |  |   |  |   | 2a. DATE OF DEATH<br>2-20-84   |   |  | 2b. HOUR<br>0320 M   |   |
| 3. SEX<br>m  |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH 2 DAY 19 YEAR 84  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS   |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. CITY MD.  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>INFANT                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE CITY   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1403 WINSTON 21239   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN WOODARD   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNIE   |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |   | 17. INFORMANT ADDRESS  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>7651</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>HYPOXIA</u><br>(c) <u>PREMATURITY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hours<br>birth, 9 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br>Peta F. Landman  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>2-20-84  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Peta F Landman  |  |   |  |   | 22e. ADDRESS<br>Sinai Hospital, Belvedere at Greenspring   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  |   | 23b. DATE<br>2-22-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sinai Hospital   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Sinai Hospital   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 9 1984  |   |  |  |   |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson Randall  |  |   |  |   |  |   |  |  |   |

FILED

10/10/19

Handwritten notes and signatures are visible throughout the page, including a large signature at the bottom center and various smaller markings and text fragments.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

04612

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Pearl M Woods</u>                    |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <u>Feb 20 84</u> |  |  | 2b. HOUR <u>8:10 PM</u>  |  |  |  |
| 3. SEX <u>Female</u>  |  | 4. RACE <u>Black</u>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <u>5 2 1920</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u>  |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Bull Gap Tenn</u>              |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Deaton N/A</u> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Ret Domestic</u>            |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Ret Farming</u>       |  |
| 13a. STATE <u>MD</u>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN <u>Baltimore</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <u>626 N. H. Iron St</u>               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Steve Woods</u>                      |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>HARRIETT</u>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> |  |  | 16b. SOCIAL SECURITY NO.                          |  |  | 17. INFORMANT ADDRESS <u>Vincent Powell 626 N. H. Iron St</u>                                |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sepsis3109

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Decubitus ulcers

DUE TO, OR AS A CONSEQUENCE OF

(c) Organic Brain Syndrome

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Within 1 day> 6 months> 3 years

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Bronchospasm, cerebrovascular accident

MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-28-83</u> , 19 <u>84</u> , to <u>2-20</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2-20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>Candace I. Chandler MD.</u>  |  |   |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <u>2-21-84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CANDACE I. CHANDLER</u>   |  |   |  | 22e. ADDRESS <u>DEATON MEDICAL CENTER BALTIMORE MD</u>  |  |   |  |

|   |  |                          |  |  |  |   |  |
|---|--|--------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> |  | 23b. DATE <u>2/25/84</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>St AUGUSTINE</u> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore MD</u> |  |
| 24. FUNERAL DIRECTOR <u>Mr. HAYES 638 N. Gilman St</u>  |  |                          |  | 25a. DATE REC'D. BY REGISTRAR <u>FEB 23 1984</u>       |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NELLIE PERSOL WRIGHT</b>  |  |   | 7a. DATE OF DEATH<br><b>Feb 8 1984</b>   |  | 7b. HOUR<br><b>5:32 PM</b>  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>11--18--1895</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>   |  | 8. UNDER 1 YEAR<br>MONTHS _____ DAYS _____ HOURS _____ MIN. _____ |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Long Green</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> NO <input type="checkbox"/>   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Robert Lee</b> MIDDLE <b>Piersol</b> LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Kate</b> MIDDLE <b>Smith</b> LAST  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-6744D</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. M.K. Pechulis 1900 Fairbank Road 21209</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>C. V.A.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>CHSCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. _____ 19 _____  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>1954</b>   |  | 21f. LOCATION<br>CITY OR TOWN <b>2-8-84</b> COUNTY <b>84</b> STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-22-84</b> 19 <b>84</b> , to <b>2-8-84</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-22-84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) work on the body of a deceased.             |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>William G. Helfrich MD</b>  |  | DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2-10-84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William G. Helfrich</b>  |  | 22e. ADDRESS<br><b>5006 Roland Ave. 21210</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>XX 2-13-84</b>  |  | NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  |   | 23c. LOCATION<br>CITY OR TOWN <b>Pikesville</b> COUNTY <b>Balto.</b> STATE <b>Md.</b>                                      |
| 24. FUNERAL DIRECTOR<br>NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Road 21212</b>  |  |   |  |  |   |  |

FEB 16 1984

Jana Davidson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR Item 4 3-6-84cn  |  |   |  | STATE OF MARYLAND  |  | 04614  |  |
|--|--|---|--|--|--|--|--|
| 1. STATE REGISTRAR   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MINNIE L YELDON</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>02 22 84</b>  |  | 2b. HOUR<br><b>12.35AM</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept 4 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>72</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ala</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>mercy hosp</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>21207</b>  |  | 12b. IND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br><b>md</b>   |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>4310 Springdale ave</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ISOM</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lela purpory</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br><b>261-07-0653</b>   |  |
| 17. INFORMANT<br><b>Ruth Mason</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SECOND DEGREE HEART BLOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MUOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>4100</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hours</b><br><b>&amp; 24 hours</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br><b>MYXEDEMA COMA</b>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 17th 1984</b> to <b>Feb 22nd 1984</b> , that (I) (we) last saw the deceased alive on <b>February 22nd 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Christine J Bell-Latterman</b> MD   |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2/22/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHRISTINE J BELL-LATTERMAN MD</b>  |  |   |  | 22e. ADDRESS<br><b>MERCY HOSPITAL ST PAUL'S PLACE</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>B</b>  |  | 23b. DATE<br><b>2/27/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Catholics me pk</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto md</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Joseph L. Russ</b>   |  |   |  | ADDRESS<br><b>2222 w yonah ave</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 24 1984</b>   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |



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CHIEFMAN



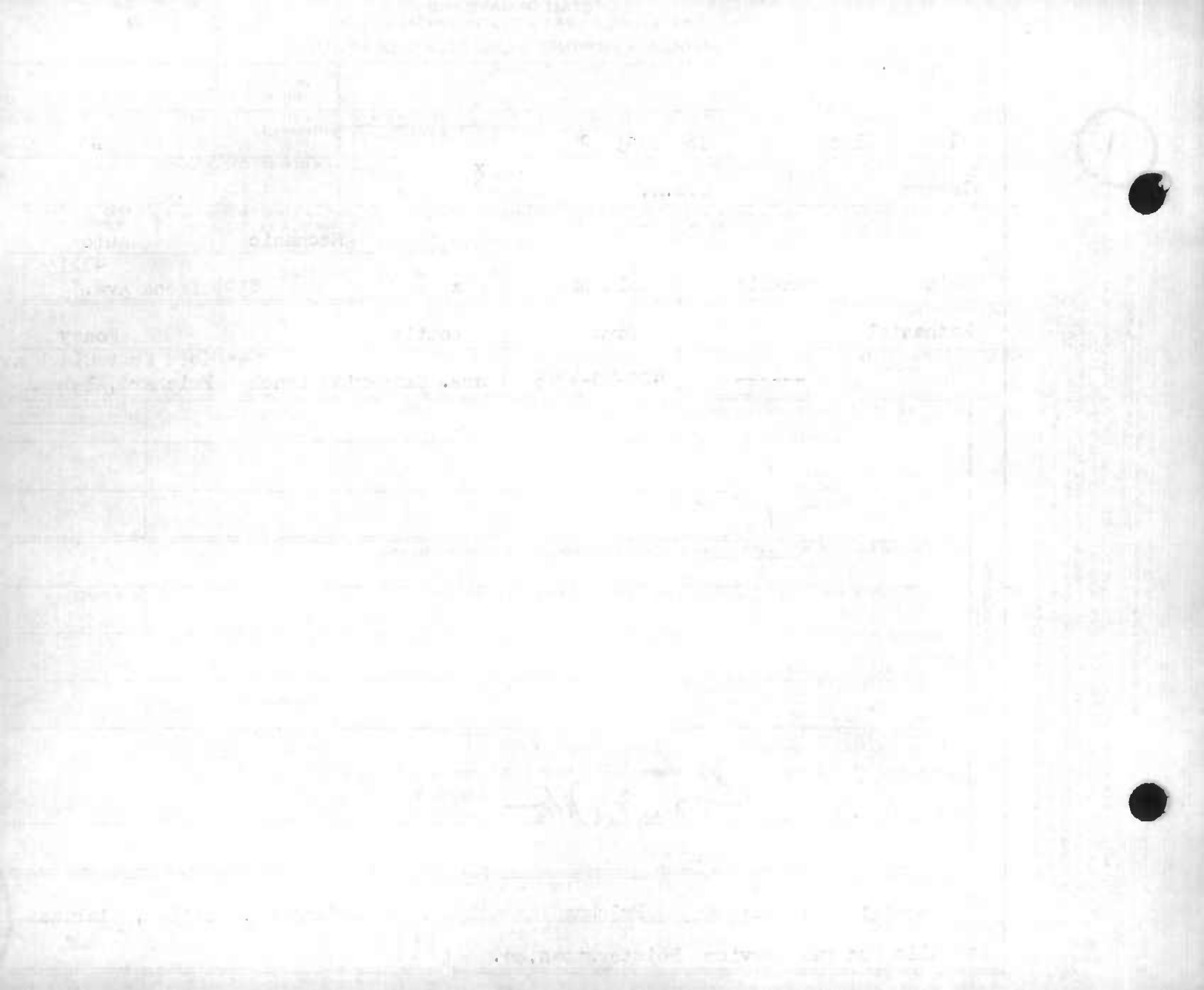
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>McCloud   |  |  | MIDDLE<br>T.  |  |  | LAST<br>York  |  |  | 2a. DATE OF DEATH<br>KNOWN<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR |  |  | 2b. HOUR<br>M                                   |  |  |   |  |  |                          |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>Black   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 16 1955   |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>28 YRS.   |  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  |  | IF UNDER 24 HRS.<br>HOURS MIN                   |  |  | 7c. DATE<br>PRONOUNCED<br>DEAD<br>2-8 1984  |  |  | 7d. HOUR<br>p. M<br>1:37 |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Alabama  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br>1102 S. Paca St. - (on street) |  |  |   |  |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Mechanic                  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Auto    |  |  |   |  |  |                          |  |  |
| 13a. STATE<br>Ohio   |  |  | 13b. COUNTY<br>Franklin  |  |  | 13c. CITY OR TOWN<br>Columbus   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>859 1/2 Leona Ave. 43215   |  |  |   |  |  |   |  |  |                          |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nathaniel York   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lottie Foney  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |  | (IF YES, GIVE WAR OR DATES)<br>-----   |  |  | 16b. SOCIAL SECURITY NO.<br>420-80-4945   |  |  | 17. INFORMANT<br>ADDRESS 1818 West Clark Av<br>Mrs. Catherine Lynch Prichard, Alabama           |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gunshot Wounds of Chest (Unspecified)<br>9654<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |   |  |  |                          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |  |  |   |  |  |   |  |  |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                          |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY<br>HOUR XX MONTH DAY YEAR<br>1:30 P.M. 2-8 1984  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was shot   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>on street  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1102 S. Paca St., Baltimore, Maryland  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
| ACTUAL<br>SIGNATURE  |  |  | TITLE (SPECIFY)<br>Dennis F. Smyth, M.D. Assistant MEDICAL EXAMINER  |  |  |   |  |  |   |  |  |   |  |  | DATE<br>SIGNED 2-8-84                           |  |  |   |  |  |                          |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |  | ADDRESS 111 Penn Street  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>2-15-84   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Prichard Memorial Cem.  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Prichard, Mobile, Alabama                         |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Marzullo Funeral Service   |  |  | ADDRESS<br>Reisterstown, Md.   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 14 1984  |  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randell   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

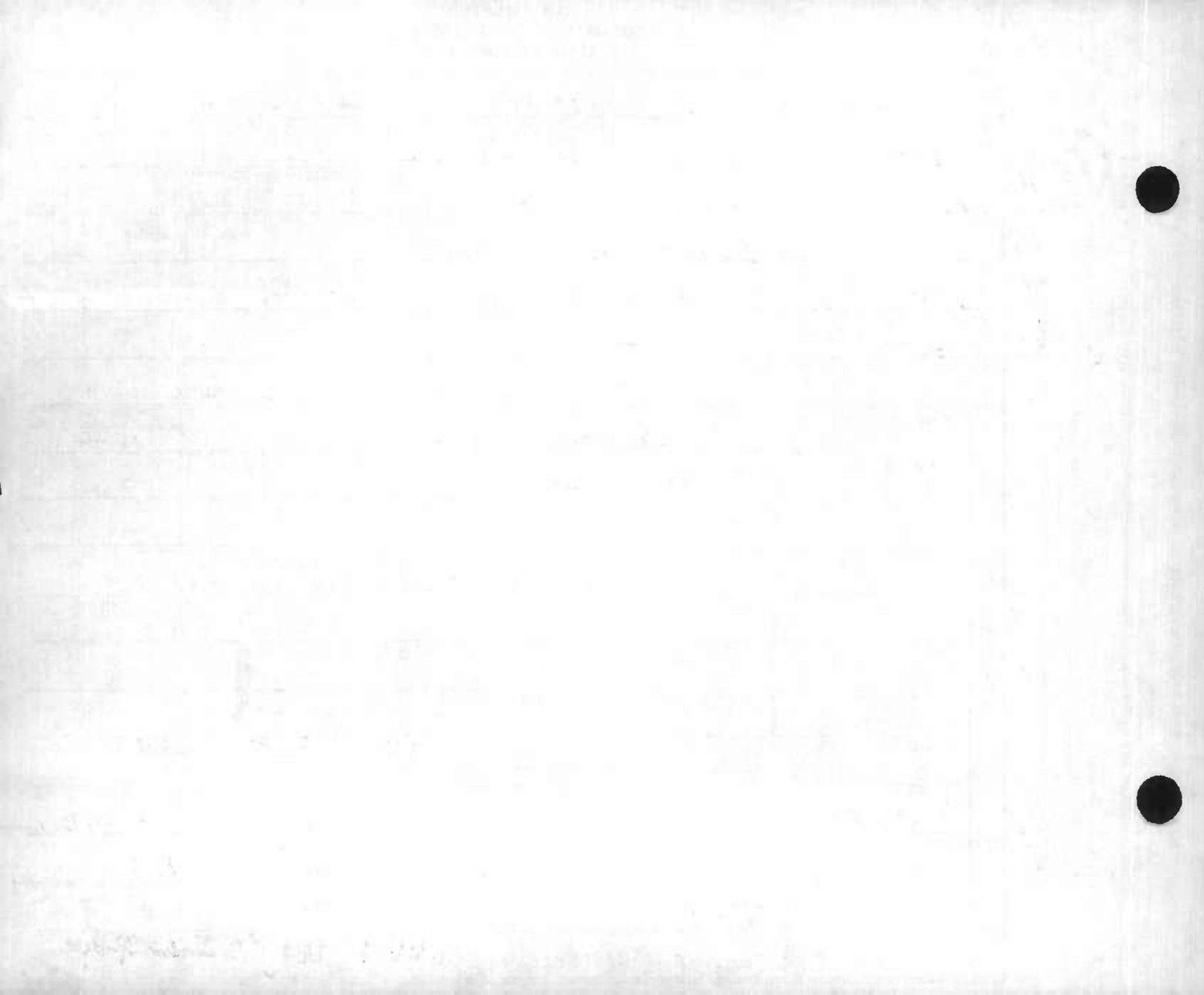
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                 |  |  |  |   | REG. NO.   |                   |
|---|-----------------|--|--|--|---|--|-------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <b>CARRIE P. Young</b>   |                 |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2/29/84</b> |  | 2b. HOUR <b>M</b> |
| 3 SEX <b>fe</b>   | 4 RACE <b>B</b> | 5. DATE OF BIRTH MONTH DAY YEAR <b>11 29 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>  |                 | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt - City</b> MD.  |                   |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Seton H. Manor</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                   |
| 13a. STATE <b>md</b>  |                 | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Perry</b>  |                 | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>- - -</b>  |  | 13e. STREET ADDRESS <b>3005 Grayson Street 21216</b>   |   |  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |                 | 16b. SOCIAL SECURITY NO. <b>217091514</b>  |  | 17. INFORMANT ADDRESS <b>George Allen 915 Argonne Drive</b>  |   |  |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>severe ASCVD</b><br>(c) <b>severe kidney disease</b>                             |                 |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min.</b><br><b>3 yrs.</b>  |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>uremia due to severe kidney disease</b>   |                 |  |  |  |   |  |                   |
| 19a. DATE OF OPERATION  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                 | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> , 19 <b>84</b> , to <b>2/29</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |                 |  |  |  |   |  |                   |
| 22b. SIGNATURE <b>Jaime Punzalan</b>  |                 |  |  | DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |   | 22c. DATE SIGNED <b>2/29/84</b>  |                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |                 |  |  | 22e. ADDRESS <b>5214 Hampden Rd. Balt. 21214</b>   |   |  |                   |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |                 | 23b. DATE <b>3/3/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>  |                   |
| 24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>   |                 |  |  | 25. DATE REC'D. BY REGISTRAR <b>MAR 1 1984</b> REGISTRAR'S SIGNATURE <b>Re Davidson-Randall</b>  |   |  |                   |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical record must be notified once.

| 1 - FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 04617   |                                   |   |  |
|--|--|---|--|---|--|--|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>OPHELIA ELIZABETH YOUNG</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>22</b> YEAR <b>84</b>  |  |  |  | 2b. HOUR <b>8:45 A</b>   |                                   |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLK</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>4</b> YEAR <b>20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |                                   | 7b. UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE<br>(COUNTRY) <b>ND CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.   |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2747 W. NORTH AVE</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK - SOCIAL SECURITY ADMIN</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2747 W. NORTH AVE. 21216</b>  |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>WALTER</b> MIDDLE <b>GOLDSTON</b> LAST <b>LUETTA</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LUETTA</b> MIDDLE <b>TAYLOR</b>  |  |  |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-20-7841</b>  |  | 17. INFORMANT<br><b>MRS JANICE C. JOHNSON</b>   |  |  |  | ADDRESS<br><b>1534 NORTHWICK RD 21218</b>  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 ACUTE CORONARY Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HASCD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPN. BRAIN TUMOR 1972</b> |  |   |  |   |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>HYPN. BRAIN TUMOR 1972</b>   |  |   |  |   |  |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-22-84</b> to <b>12-22-84</b> , that (I) (we) lost saw the deceased alive on <b>12-22-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |                                   |   |  |
| 22b. SIGNATURE<br><b>A. Enrique</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. ENRIQUE</b>   |  |   |  | 22e. ADDRESS<br><b>2435 W. BELVEDERE 21215</b>  |  |  |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2-25-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PARK</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY, MARYLAND</b>  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>NUTTER &amp; SONS</b>   |  |   |  | ADDRESS<br><b>2501 GWYNNS FALLS PARKWAY</b>   |  |  |  | 25a. DATE RECD. BY REGISTRAR<br><b>FEB 23 1984</b>   |                                   |   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rendall</i>  |  |  |  |  |                                   |   |  |

RECEIVED

STATE

CLERK - SOCIAL SECURITY ADMIN

STATE W. NORTH AVE

BALTIMORE

STATE W. NORTH AVE. 2210

BALTIMORE

MARYLAND

TAYLOR

WALTER

GOLDSTEIN

WALTER

222-50-7041 THE JAMES C. JOHNSON 1934 MORTIMER RD

NO

RECEIVED SOCIAL SECURITY ADMIN BALTIMORE COUNTY, MARYLAND

1-28-61

RECEIVED

WALTER & SONS 2201 GUYTON ELLIS TAVELLY

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH04618  
REG. NO.

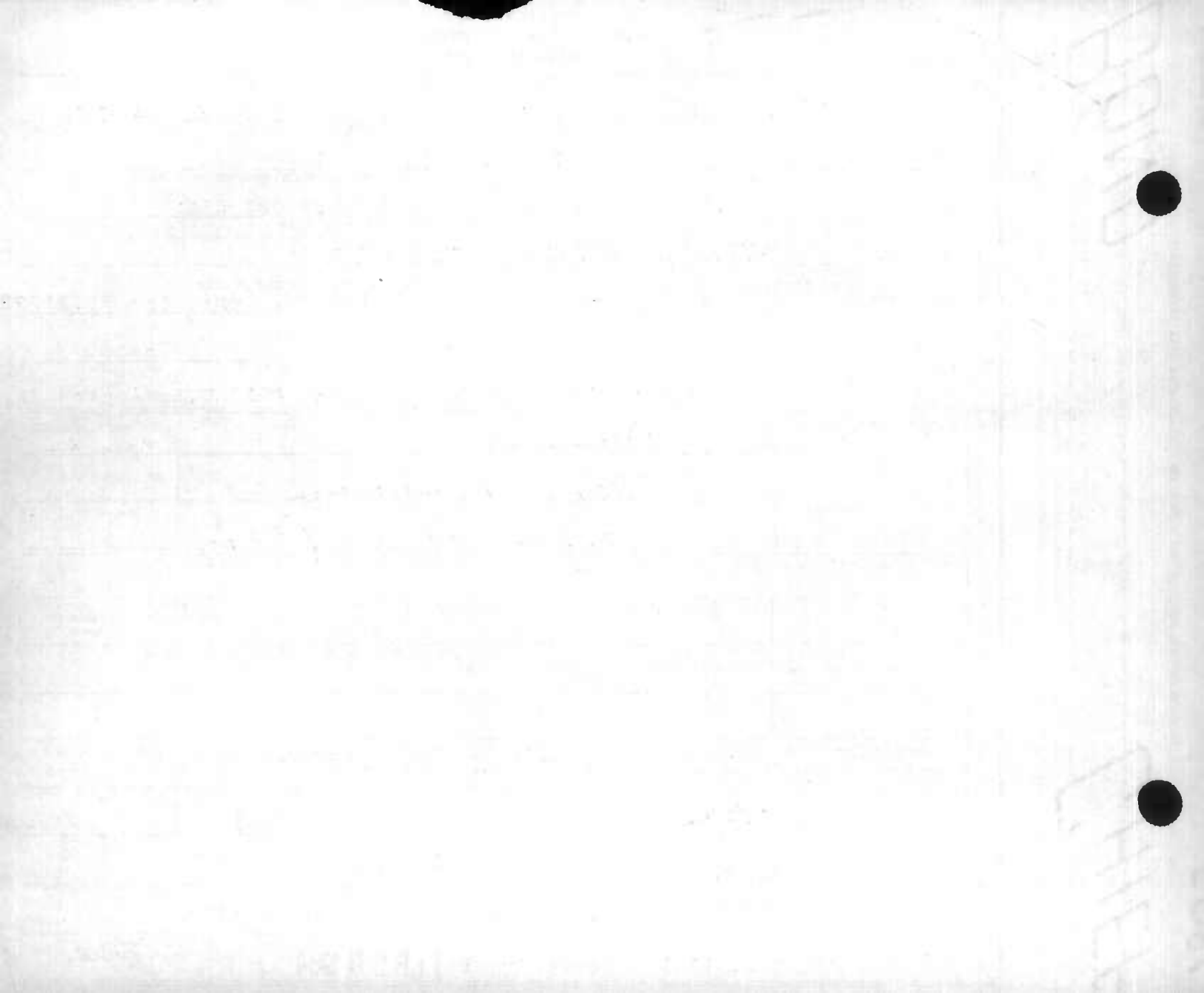
|   |  |  |  |   |  |   |   |  |  |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT RUFUS YOUNG</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 26 84</b>  |   |  | 2b. HOUR<br><b>1:15p M</b>  |   |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 29 91</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.                         |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>        |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Issac Young</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Gantt</b>  |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1613 W. Lexington St. 21223</b>      |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>21705-6827</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Douglass Sparrow 1613 W. Lexington St.</b>      |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4860 IMMEDIATE CAUSE (a) Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe Debilitation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Extreme of Age (93yo)</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b>  |  |  |  |   |  |   |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b> |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEBRUARY 18</b> , 19 <b>84</b> , to <b>FEBRUARY 26</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>FEBRUARY 26</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death. |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Clarence Smith</b>   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Clarence Smith</b>  |  |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>3/2/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cemetery</b>              |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville, Md.</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 28 1984</b>                            |   |   |  |  |
| ADDRESS<br><b>1101 E North Avenue</b>   |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                     |   |   |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Roy A. Young</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 20, 1984</b> |   |  | 2b. HOUR<br><b>9:06pm</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 18 1917</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Vermont</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corporation</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Millwright</b>                                      |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>American Can</b>  |  |   |   |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   | 13e. STREET ADDRESS<br><b>13 Lombardy Drive 21222</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leon Young</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Irma Naphtaly</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |   | 17. INFORMANT<br><b>Gary A. Young</b>   |  | 18. ADDRESS<br><b>1023 Isabella Drive Stafford, Va. 22554</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4225 IMMEDIATE CAUSE (d) CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.     |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)<br><b>Bleeding &amp; esophageal Varices</b>  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>MOTY</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB. 20</b> , 19 <b>84</b> , to <b>FEB. 20</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>FEB. 20</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Moti L. Kouil</i>  |  |   |   | DEGREE  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MOTI L. KOUIL MD</b>  |  |   |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 N. BROADWAY BALTO. MD 21231</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/23/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.<br/>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

RECEIVED

20% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Betty Youngblood</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Feb 17 1984</b>  |  |  |  |
| 3. SEX <b>Female</b>  |  |   |  | 2b. HOUR <b>1:15 PM</b>  |  |  |  |
| 4. RACE <b>Negro</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALT</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALT. CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Balt.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hosp. of Balt</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>—</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. STREET ADDRESS <b>21207 4203 Springdale Ave</b>   |  |  |  |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>BALT</b>   |  | 13c. CITY OR TOWN <b>BALT</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLIE</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSA</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>212 16 0148</b>   |  | 17. INFORMANT ADDRESS <b>ESTHER MONTGOMERY 6502 EBERLE DR. APT. 10</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ESOPHAGEAL VARICES</b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>END STAGE CIRRHOSIS</b>   |  |   |  |  |  |  |  |
| (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Renal Failure 2° to ABOVE</b>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 17 19 84</b> to <b>Feb 17 19 84</b> , that (I) (we) last saw the deceased alive on <b>Feb 17 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>Robert De Marco, MD</b> DEGREE  |  |   |  | 22c. DATE SIGNED <b>2/17/84</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT DE MARCO, MD</b>  |  |   |  | 22e. ADDRESS <b>Sinai Hosp of BALT.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>2/22/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b> <b>JAMES D. RENDALL</b>   |  |  |  |

BP

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Handwritten notes on lined paper, including a circled '2' in the top right corner and a large 'X' mark in the bottom left corner. The text is mostly illegible due to fading and bleed-through from the reverse side of the page.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 4 6 2 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |   |  |  |  |
|--|--|---|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Linda D. Yurth</b>                        |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Feb. 24, 1984</b> |   |   | 2b. HOUR<br><b>11:00 P.M.</b>  |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 13, 1953</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>31</b>                     |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2031 Eastern Avenue</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>----- |  |  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br>-----                                     |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>21231.<br/>2031 Eastern Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert H. Webb</b>                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy Amber Jett</b>  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>No</b> |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-64-5362</b>           |   | 17. INFORMANT <b>Baltimore, Md. 21231.</b><br><b>Michael D. Yurth-2031 Eastern Ave.</b> |  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1749

**CANCER OF THE BREAST WITH  
WIDESPREAD METASTASIS**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)            |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 15</b> , 19 <b>84</b> , to <b>FEB. 24</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>FEB. 24</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Lydia M. Jummoy, M.D.</b>   |  |  |  | DEGREE<br><b>ATTENDING MEDICAL STAFF<br/>PHYSICIAN DIRECTOR PHYSICIAN</b>                 |  | 22c. DATE SIGNED<br><b>2/25/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LYDIA M. JUMMOY, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL, 100 W. BROADWAY<br/>BALTIMORE, MD. 21201</b>          |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/27/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Memorial Park-Howard County, Md.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD. 21231</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>John A. Moran, Inc., Funeral Home<br/>3000 E. Baltimore St. - Baltimore, Md. 21224</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 27 1984</b>                                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Sanders</b>  |  |

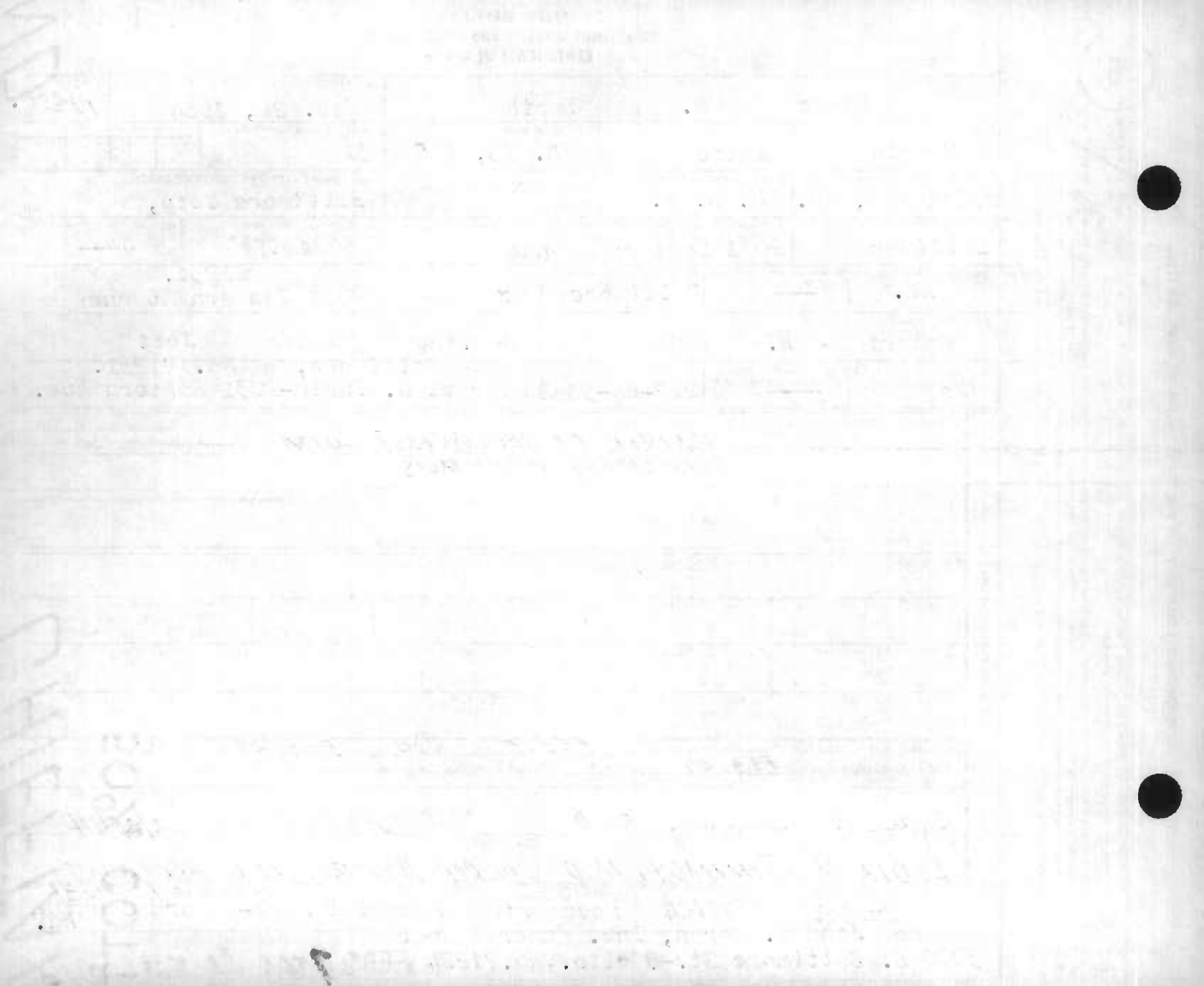
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP  
DHMH - 16 50M 4/82  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

89-04522

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                            |   |  |
|--|--|---|---|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary Alvey Zadra</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 27 84</b> |   | 2b. HOUR<br><b>5:06 PM</b> |   |  |
| 1 SEX<br><b>Female</b>   |  | 4 RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 24 00</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hagerstown MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto Md</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Keswick</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Librarian</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>College</b>                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>FLA</b> |  |   |   | 13b. COUNTY<br><b>Winterhaven</b>   |                            | 13c. CITY OR TOWN<br><b>Winterhaven</b>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard H. Alvey</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lelia Scott</b>   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>219 22 8655</b>  |                            | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Margaret A. Mudge, MD 21204</b> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**1539**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Aspirin & the color**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Aspirin brain syndrome**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**3 days****1 year**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)    |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-26</b> , 19 <b>79</b> , to <b>2-27</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-21</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>E. Hunter Wilson</b>  |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>2-27-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. E. Hunter Wilson, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>Keswick Home, Balto., MD 21211</b>                                |  |  |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>       |  | 23b. DATE<br><b>2/28/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 29 1984</b>         |  |   |  |
| 4905 York Road Balto., MD 21211  |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Handall</b> |  |   |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1. RECEIVED NAME<br>Matthew Zahner<br>MATTHEW F. ZAHNER  |  | 2a. DATE OF DEATH<br>FEBRUARY 24 84  |  | 2b. HOUR<br>5 <sup>05</sup> A.M.  |   |
| 3. SEX<br>Male   |  | 4. RACE<br>Cauc.   |  | 5. DATE OF BIRTH<br>4 18 1924   |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital                     |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Hearing Officer State   |   |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Matthew Zahner   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Josephine Hurkar  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II   |  | 17. INFORMANT<br>ADDRESS<br>Margaret Zahner 7224 Gough St. 21224  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4275 CARDIO Respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ANOXIA<br>DUE TO, OR AS A CONSEQUENCE OF (c) STATUS POST CARDIAC ARREST, SURVIVED<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Minutes<br>DAYS<br>DAYS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>CHRONIC RENAL FAILURE  |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 2/22 19 84 to 2/24 19 84, that (I) (we) last saw the deceased alive on 2/24 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |
| 27a. SIGNATURE<br>George Markus  |  | DEGREE   |  | 27b. DATE SIGNED<br>2/24  |   |
| 27c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George Markus   |  | 27d. ADDRESS<br>BALTO City Hospital  |  | 27e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/27/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cem.   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>B. Dabrowski & Son 2818 E. Baltimore St.   |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 27 1984   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_

DHMM - 16 50M 4/82  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.  |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Laura G. ZALE</i>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><i>February 22 84 1221 AM</i>                      |  |  |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>3 4 1931</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>52</i> YRS.                                    |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maine</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hospital</i> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Dundalk</i>   |   | 13e. STREET ADDRESS<br><i>8 Winona Avenue 21222</i>                                  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Paul W. Brichetto</i>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Agnes Hoff</i>                                 |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>218-28-4664</i>  |  | 17. INFORMANT ADDRESS<br><i>Milton L. Zale Same as 13e</i>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4/100 Cardio Respiratory Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarct</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>hours</i>   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>minutes</i>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Cigarette Abuse</i>  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/21</i> , 19 <i>84</i> , to <i>2/22</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>2/22/84</i> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>George Markus</i>   |  | DEGREE<br><i>MD</i>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   |  |  | 22c. DATE SIGNED<br><i>2/22/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>George Markus</i>  |  |   |  | 22e. ADDRESS<br><i>Balto City Hosp Balto MD 21224</i>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>2/25/1984</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Rosary</i>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i>              |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Duda-Ruck, inc.</i>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |
| 7922 Wise Avenue Dundalk, MD. 21222  |  |   |  |   |   | FEB 23 1984  |  |  |  |

RECEIVED  
MAY 19 1964

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TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The body of the letter contains several paragraphs of extremely faint, illegible text.]



FOR THE DIRECTOR

DATE

BY [illegible]

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CAROLE L. ZERHUSEN</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 17 84</b> |   |  | 2b. HOUR<br><b>2:40A</b> M  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 26, 1954</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>30</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE City</b>             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  |
| 13a. STATE<br><b>Maryland</b>                                  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Jackson</b> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Barbara ? INGRAM ?</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>219-62-4138</b>                 |  | 17. INFORMANT<br><b>Robert J Zerhusen</b>  |  | ADDRESS<br><b>Same As 13E</b>   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhagic pneumonitis</b><br><b>4229</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| (b) <b>Acute myocarditis, probably viral</b>  |  |  |  |
| (c)   |  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/16</b> , 19 <b>84</b> , to <b>2/17</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Veneranda G. Barnes M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>2/17/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VENERANDA G. BARNES</b>  |  |  |  | 22e. ADDRESS<br><b>NORTH CHARLES GEN. HOSP.</b>                                      |  |  |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                             |  | 23b. DATE<br><b>2/20/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 21 1984</b>        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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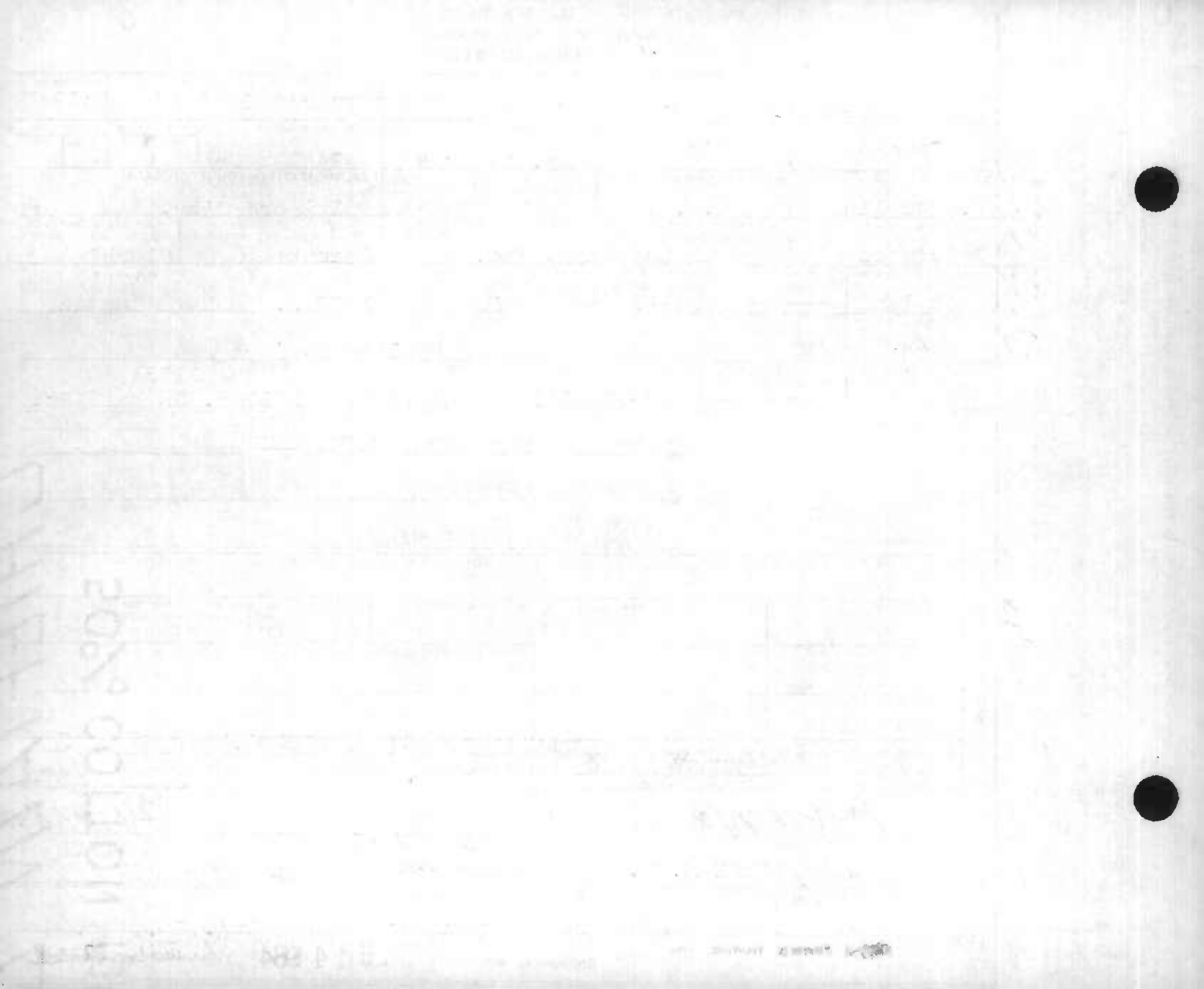
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCES P. ZIBRON</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 10 1984</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 5, 1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital, Inc.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>-----</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Majka</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pauline Skwirut</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-09-1121</b>  |  | 17. INFORMANT ADDRESS<br><b>Joseph Michael 1737 E. Lombard St. 21231</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>CARCINOMA COLON WITH METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>METASTASIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 19, 1984</b> to <b>FEBRUARY 10, 1984</b> , that (I) (we) lost saw the deceased alive on <b>FEBRUARY 10, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>A. F. Nazemi M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/10/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ATAOLLAH NAZEMI M. D.</b>   |  |   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL 100 NORTH BROADWAY 21231</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb 14, 84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus Bldg Co. Md.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>DePal Funeral Homes, Inc.</b>  |  |   |  | ADDRESS<br><b>7110 Belair Road Baltimore, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 14 1984</b>  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendell</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  |   | REG. NO.                                  |  |
|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE F. ZIMMERMAN</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/22/84</b>                      |   | 2b. HOUR<br><b>1150 A</b>                 |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 24 08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt MD</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. of MD. Hospital</b>                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Balt Steel Ret. Policeman</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>   |   | 13b. COUNTY<br><b>---</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRED ZIMMERMAN</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CAROLINE Anne Muir</b> |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>213-07-5417</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Theresa R. Zimmerman Same as #13</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4280 Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>probable sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>congestive heart failure</b>   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>NA</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 8</b> , 19 <b>84</b> , to <b>Feb 22</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Feb 22</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>CHARRIE</b>  |   | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/22/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARRIE</b>   |   | 22e. ADDRESS<br><b>Univ. of MD. Hospital</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/25/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, A. A. Co., Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCutty Funeral Homes</b>  |   | BALTA., MD., 21225<br><b>237 E. Patapsco Ave.,</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |                                   |  |   |  |  |  |
|---|--|--|---|---|-----------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROSINA W ZITO</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 29, 1984</b>             |   |                                   | 2b. HOUR<br><b>5:55A<sup>M</sup></b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 8 06</b>   |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>77</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |   |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Maker</b>   |  |  |
| 13a. STATE<br><b>Florida</b>  |  |  | 13b. COUNTY<br><b>Dade</b>  |   | 13c. CITY OR TOWN<br><b>Miami</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>3810 South West 68th Ave 33155</b>   |  |  | 13f. STREET ADDRESS / ZIP CODE<br><b>3810 South West 68th Ave 33155</b> |   |                                   | 13g. STREET ADDRESS / ZIP CODE<br><b>3810 South West 68th Ave 33155</b>  |   |  |  |  |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Rudolf Walter</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Haigis</b>    |   |                                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                              |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>264-62-7759</b>  |  |  | 17. INFORMANT<br><b>Charles Zito</b>                                    |   |                                   | 17. ADDRESS<br><b>Linthicum, Md 21090</b>  |   |  |  |  |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>3568</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Progressive Supranuclear Palsy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2/years</b> |  |  |   |   |                                   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).  |  |  |   |   |                                   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |   |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Feb 10</b> , 19 <b>84</b> , to <b>Feb 29</b> , 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>Feb 29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |  |   |   |                                   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>John S. Gilbert</b>  |  |  | DEGREE<br><b>GILBERT</b>  |   |                                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/29/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GILBERT</b>   |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                           |   |                                   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>3/3/84</b>  |   |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore == Md</b> |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy, Balto</b>  |  |  |   |   |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1984</b>   |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                                  |   |  |   |  |  |  |
|--|--|--|----------------------------------|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |                                  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Ida Zussman</i>   |  |  |                                  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>2/5/84</i>   |  | 2b. HOUR<br><i>7:55 PM</i>   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>WHITE</i>  |                                  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>09-18-1894</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>89</i>  |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Russia</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i>                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Levinthal Heb Home &amp; Hospital</i> |                                  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |                                  |   |  |   |  |  |  |
| 13a. STATE<br><i>MARYLAND</i>  |  | 13b. COUNTY<br><i>BALTIMORE</i>  |                                  | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>APT. 414<br/>2500 W. BELVEDERE AVE. 21215</i>              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>MORRIS HIMELFARB</i>   |  |  |                                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>ZLOTA UNKNOWN</i>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO</i>   |  |  |                                  | 16b. SOCIAL SECURITY NO.<br><i>218-32-4727</i>  |  | 17. INFORMANT<br><i>MRS. RUTH WINNER</i><br><i>8423 CHARLTON RD. RANDALLSTOWN, MD 21133</i>     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4149</i> IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>ISCHEMIC HEART DISEASE</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>immed</i> |  |  |                                  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>SEVERE HEMOLYTIC ANEMIA</i>   |  |  |                                  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |                                  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |                                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> OR NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |                                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-1-83</i> to <i>2-5-84</i> , that (I) (we) lost <i>2-5-84</i> above, (I) (we) (did) (did not) view the body after death.  |  |  |                                  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |                                  | DEGREE<br><i>[Signature]</i>  |  |   |  | 22c. DATE SIGNED<br><i>2-6-84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>B-RAW-WIN, MD</i>  |  |  |                                  | 22e. ADDRESS<br><i>6801 Belair Rd 21206</i>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |  | 23b. DATE<br><i>FEB. 7, 1984</i> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>FORBAND</i> |   | 23d. LOCATION<br><i>ROSEDALE BALTO. MD</i> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>SOL LEVINSON &amp; BROS. INC.</i><br>ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>   |  |  |                                  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 10 1984</i>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |                                  |   |  |   |  |  |  |

BP

STANDARD FORM NO. 64

OFFICE OF THE  
DIRECTOR

WASHINGTON, D. C.

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